Incident Witness Statement

This is not a report of injury form. Please report the injury online at www.mem-ins.com or by calling 1.800.442.0593.

Name of Witness	Date of Incident	Time of Incident ________ ❒ A.M. ❒ P.M.	Date Reported
Department	Job title		Hire Date
Employer (*if not an employee*)	Phone number (*if not an employee*)		Name of Supervisor
Location of Incident			
Name of Injured Employee			
Name of Injured Employee's Employer/MEM Policy No.	Employer's Phone Number		
Description of Incident			
Physical Conditions at the Time of Incident			
Any other witnesses? ❒ Yes ❒ No	Name	Name	Name
Were there others injured? ❒ Yes ❒ No	Name	Name	Name
Report Completed by	Signature		Date
Title	Employer		

Submit completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597

Email: claims@mem-ins.com