

# WITNESS INFORMATION FORM

Fax or Email this completed form to FAS (972) 930-9479 or CLAIMS@FASTPA.COM

EMPLOYER NAME: \_\_\_\_\_

INJURED EMPLOYEE: \_\_\_\_\_

DATE OF INCIDENT: \_\_\_\_\_ TIME OF INCIDENT: \_\_\_\_\_ AM \_\_\_\_ PM \_\_\_\_

NAME OF WITNESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

EMPLOYEE? YES  NO  TITLE \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NAME OF WITNESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

EMPLOYEE? YES  NO  TITLE \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NAME OF WITNESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

EMPLOYEE? YES  NO  TITLE \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NAME OF WITNESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

EMPLOYEE? YES  NO  TITLE \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## SUPERVISOR/MANAGER COMPLETING REPORT

\_\_\_\_\_  
Supervisor / Manager      Name Printed

\_\_\_\_\_  
Supervisor / Manager      Signature

\_\_\_\_\_  
Date: