

WITNESS STATEMENT

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

EMPLOYER INFORMATION: _____

ADDRESS: _____ City: _____ State TX Zip: _____

PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

NAME OF WITNESS _____ HOME PHONE _____

HOME ADDRESS _____ CITY _____ STATE ____ ZIP _____

TITLE _____ DEPT. _____ WORK PHONE _____

DATE OF INCIDENT _____ TIME OF INCIDENT _____ A.M. ____ P.M. ____

THIS STATEMENT CONCERNS MY KNOWLEDGE OF THE ALLEGED INCIDENT.

1. NAME OF INJURED EMPLOYEE: _____

2. IF NOT EMPLOYEE, REASON FOR PRESENCE AT LOCATION: _____

3. ARE YOU RELATED TO INJURED EMPLOYEE? _____ HOW? _____

4. HOW LONG HAVE YOU KNOWN THIS EMPLOYEE? _____

5. PLEASE EXPLAIN IN DETAIL WHAT YOU KNOW ABOUT THIS INCIDENT: (NAME SPECIFIC INDIVIDUALS, OBJECTS OR EQUIPMENT)

6. DID YOU ACTUALLY SEE THE INCIDENT? _____ IF NOT, HOW DID YOU HEAR ABOUT IT? _____

7. DO YOU KNOW OF ANY OTHER INJURY, INCIDENT OR ILLNESS THAT THIS EMPLOYEE HAS HAD? _____ IF SO, EXPLAIN: _____

8. GIVE THE NAMES AND ADDRESSES OF ANY OTHER PERSONS WHO MIGHT KNOW ABOUT THIS INCIDENT:

9. ADDITIONAL COMMENTS: _____

I certify that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: _____
Signature

Date: _____

Verified by: _____
Signature

Date: _____

Translated By (If Applicable): _____ Date: _____

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.