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 and Phone No.	Name and Phone No.	Name and Phone No.
Were there others injured? ❒ Yes ❒ No	Name and Phone No.	Name and Phone No.	Name and Phone No.

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