



## WITNESS STATEMENT

**MUST BE TYPED  
OR PRINTED**

Injured Employee \_\_\_\_\_

SORM Claim Number WC \_\_\_\_\_

Date of Injury \_\_\_\_\_

Statement Taken By \_\_\_\_\_

Witness Name: \_\_\_\_\_ Witness email address: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Primary Telephone: \_\_\_\_\_ Secondary Telephone: \_\_\_\_\_

Witness Employer: \_\_\_\_\_

On this date, \_\_\_\_\_, at about \_\_\_\_\_ PM / AM I was in or at (clearly state your own location) \_\_\_\_\_ when an accident involving the above employee is reported to have occurred.

Check only one box

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**I saw the incident.**

The accident occurred in the following manner: \_\_\_\_\_

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Other pertinent information and source: \_\_\_\_\_

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**I did not see the incident.** Information given to me by (name of person) \_\_\_\_\_

indicates it occurred as follows: \_\_\_\_\_

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Other pertinent information and source: \_\_\_\_\_

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I know nothing whatsoever about the occurrence.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **Instructions Witness Statement**

### **Required:**

Immediately after receiving notice of any injury, the Claims Coordinator should determine the names, addresses, and telephone numbers of all witnesses to the incident. A statement should be taken from each witness and forwarded to SORM.

### **Filing Deadline:**

The form must be received by SORM not later than the 5th calendar day after the first notice of injury is reported to the agency.

### **Completed by:**

This form should be completed by the person giving the statement with assistance from the Claims Coordinator.

### **Instructions:**

1. Except for the witness signature, the statement should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
2. Please provide the SORM claim number, if known.
3. The witness may have actually seen the incident or may have acquired knowledge about the accident from another source. The witness information may relate to how the incident occurred or to something else that is relevant. Check the first or second box and fill in the blanks following those boxes, as appropriate. Be specific and complete. Sometimes you will be given a witness name but, when asked, denies any knowledge of the incident. In such a case the third box should be checked.
4. If the space provided on the form is insufficient please attach additional sheets. Be as specific and complete as possible.

### **Distribution:**

The Claims Coordinator shall retain the original for the agency file and fax or mail a copy to:

State Office of Risk Management  
PO Box 13777  
Austin, TX 78711  
Fax: (512) 370-9025

**Notice:** With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.