CMS **ILLINOIS**
DEPARTMENT OF CENTRAL
MANAGEMENT SERVICES

Central File No. _____

WORKER'S COMPENSATION WITNESS REPORT

Injured Employee's Name	Work Location	
Your Name	Do you work for the State of Illinois? ☐ Yes ☐ No	Work Phone
Home Address (street)	(City/State/Zip)	Home Phone

Did you see the accident? ☐ Yes ☐ No	Date you Witnessed Time ☐ A.M. ☐ P.M.	Did you know employee before the accident ☐ Yes ☐ No

What did you see or hear? – Be specific (use back side if necessary)

Exact location of what you saw or heard

Name(s) and address(es) of any other witness(es)

I CERTIFY THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Date completed Signature of Witness

Name and title of individual making report (print)

_____
Print Name