CMS **Illinois**
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

CENTRAL FILE NO. _____

WORKERS' 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..

_____ Date completed

_____ Signature of Witness

Name and title of individual making report (print)

_____ Signature