WITNESS STATEMENT

MUST BE TYPED OR PRINTED

Injured Employee Name: _____ **Date of Injury:**_____

SORM Claim Number: _____ **Statement Taken By:** _____

Witness Name: _____

Witness Email Address: _____

Residence Address: _____

Primary Telephone:_____ **Secondary Telephone:** _____

Witness Employer: _____

On _____**, at about** _____ **in the** ☐ **a.m. /** ☐ **p.m., I was in or at** _____ **when an accident involving the above employee is reported to have occurred.**

SELECT CHOICE A, B, OR C BELOW:

A. ☐ **I saw the incident.** The accident occurred in the following manner:

Other pertinent information and source:

B. ☐ **I did not see the incident.** Information given to me by (name of person):

Indicate how it occurred:

Other pertinent information and source:

C. ☐ **I know nothing whatsoever about the incident.**

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. Be as specific and complete as possible.
2. Except for the witness signature, the statement should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
3. Please provide the SORM claim number, if known.
4. 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. Sometimes you will be given a witness name but, when asked, the witness may deny any knowledge of the incident. In such a case the third box should be checked.
5. If the space provided on the form is insufficient please attach additional information.

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.