



WITNESS REPORT OF ACCIDENT

Please Fax completed form to (904) 262-2760, Attention: Risk Management Dept.

WITNESS NAME: _____ SS#: _____
(Please Print)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF INJURED EMPLOYEE: _____

NAME OF CLIENT COMPANY: _____

DATE/TIME OF ACCIDENT: _____ LOCATION: _____

WHERE WERE YOU WHEN ACCIDENT OCCURRED? _____

WHAT WERE YOU DOING WHEN ACCIDENT OCCURRED? _____

DESCRIBE WHAT YOU SAW: _____

DESCRIBE THE INJURIES IN DETAIL: _____

WHEN WAS A SUPERVISOR NOTIFIED? _____ BY WHOM? _____

NAME(S) OF OTHER WITNESSES: _____

DESCRIBE ALL FACTORS YOU BELIEVE CONTRIBUTED TO THE ACCIDENT: _____

ARE YOU RELATED TO THE INJURED EMPLOYEE? (Y) (N) IF YES, HOW? _____

(PRINTED NAME OF WITNESS)

() _____
(PHONE)

(SIGNATURE OF WITNESS)

(DATE)

MATRIX EMPLOYEE LEASING

9016 Philips Highway

Jacksonville, Florida 32256

Phone: (904) 739-2722 Fax: (904) 262-2760