WITNESS/CO-WORKERS STATEMENT

I, _____ was present at the time the
(Name of witness)

employee, _____ reportedly had an on-the-job injury.
(Name of injured employee)

I did _____ did not _____ witness the injury that occurred.

The following is a brief description of what I observed on the injury date of

_____ at approximately _____ AM _____ PM _____.
(Date) (Time)

_____
_____
_____
_____
_____
_____
_____
_____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

_____ _____
Signature of Witness Date

_____ _____
Signature of Employer Date

SEND ORIGINAL TO:
Claims Administrative Services
Old Glory Insurance Company
P.O. Box 7500
Tyler, TX 75711
Phone: (800) 765-2412
Fax: (903) 509-1888

Any person who commits workers compensation fraud, upon conviction, shall be guilty of a felony.