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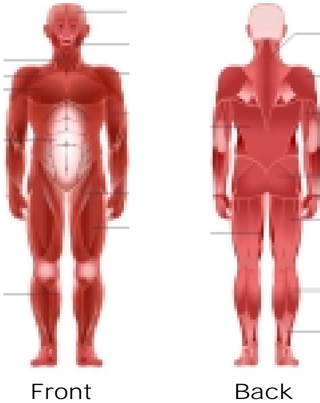
simplifying employment

WITNESS REPORT OF INJURY/ILLNESS

*Complete within 24 hours of injury and fax to CoStaff at 248.**671.0802***

Witness Name		Social Security Number	
Witness Address, City, State, Zip			
Witness Phone		Date of Birth	
Injured Employee Name			
Date of Injury		Time of Injury	
Location of Injury			
Work-Site Employer Name			

Mark areas of injury below.



CAUSE	TYPE OF INJURY
☐ Slip and fall	☐ Scrape / Bruise
☐ Struck by equipment	☐ Sprain / Strain
☐ Lifting or moving	☐ Puncture wound
☐ Caught (in, on or between)	☐ Cut / Laceration
☐ Puncture	☐ Concussion
☐ Object in eye (☐ Left ☐ Right)	☐ Bite
☐ Repetitive / Overuse	☐ Chemical Burn/Rash/Breathing Issues
☐ Other: ______________________	☐ Other: ______________________
______________________	______________________
______________________	______________________

Describe details of the injury and how it occurred.

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Name of others who may have witnessed the injury:

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Thank you for assisting us with this matter. Please sign and date this form.

Witness Signature ______________________________ Date ______________