



Kentucky Employers' Mutual Insurance
making workers' comp work®

WITNESS STATEMENT(S)

Name _____ Employee Yes No
Address _____
Phone _____ Occupation _____ Years Experience _____

Witness Signature _____ Date ____ / ____ / ____

Name _____ Employee Yes No
Address _____
Phone _____ Occupation _____ Years Experience _____

Witness Signature _____ Date ____ / ____ / ____