Insurance Commission
of Western Australia

Government Insurance Division

Level 15, Tower 2, Mia Yellagonga
5 Spring Street
Perth WA 6000

GPO BOX L920
Perth WA 6842

Tel: (08) 9264 3333
icwa.wa.gov.au

Workers Compensation Claim
Witness Statement

The Insurance Commission of Western Australia is collecting your personal information through this witness statement form for the purpose of assessing and managing an insurance claim. For further information on how we handle your personal information, please read our Privacy Policy at icwa.wa.gov.au/privacy.

Workers details

Last name:	First name:

Witness details

Last name:	First name:
Date of birth:	
Address:	
Phone:	Email:
Employers' name:	Occupation:
Relationship to claimant: Co-worker ☐ Relative ☐ Other ☐ Please specify:	

Incident details

Date of incident:	Time of incident: am/pm
Place of incident:	
Type of injury (burn, cut, fracture etc.):	
Location of injury (upper arm, lower back etc.):	

Were you a witness? Yes ☐ No ☐

If yes, please describe what you witnessed:

If no, how did you become aware of the incident?

Declaration

Section 526 of the *Workers Compensation and Injury Management Act 2023* provides that any person who fraudulently obtains or fraudulently attempts to obtain any benefit under this Act by malingering or by making a false claim or statement commits an offence.

I declare that the details submitted are true and correct.

Signature of witness: Date:

Witness name: