



Workers' Compensation and Injury Management Branch
20 Stockton Bend, Cockburn Central WA 6164
GPO Box P1174, Perth WA 6844
Tel: (08) 9395 9300
Email: volunteer.injurymanagement@dfes.wa.gov.au

Volunteer Injury 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. This information will be used to assess and manage the insurance claim. For further information on how we handle your personal information, please read our Privacy Policy at icwa.wa.gov.au/privacy.

Volunteer details

Last name:	First name:
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Witness details

Last name:	First name:
Date of birth:	
Address:	
Phone:	Email:
Employers' name:	Occupation:
Relationship to claimant: Co-volunteer <input type="checkbox"/> Relative <input type="checkbox"/> Other <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
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 making any false claim or statement, and any person who, by false statement or other means, aids or abets a person in so obtaining or attempting to obtain, commits an offence.

I declare that the details submitted are true and correct.

Signature of witness: _____ Date: _____

Witness name: _____