Insurance Commission of Western Australia

Government Insurance Division

Level 13, Forrest Centre
221 St Georges Terrace
Perth WA 6000

GPO BOX K837
Perth WA 6842

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

Workers' Compensation Claim Witness Statement

Worker 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 308 of the *Workers' Compensation and Injury Management Act 1981* 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:	