

**WITNESS LETTER**

BWC Logo

(Project Use Only - Corr4D)

mm/dd/yy

Addressed to:  
(Witness Address)

Injured Worker:  
Claim Number:  
Injury Date:  
Claim Type:

Employer Name:  
Policy Number:  
Employer Status:  
MCO Name:  
MCO Number:

You were listed on the claim application as a witness to the accident involving the above named injured worker. Please reply to the question(s) listed below to the best of your knowledge. If necessary, please attach an additional sheet of paper for your response.

1. Please explain how the injury occurred.
  
2. What was the injured worker doing when the injury occurred?
  
3. When did the injury happen?
  
4. Where did the injury happen?
  
5. If necessary, may we contact you? If yes, please list your telephone number where you can be reached from 7:00 A.M. to 4:45 P.M., Monday through Friday.

Please sign and date this request form and return it to the BWC service office and team indicated below. Once completed, this questionnaire will be placed in the claim file identified above and will be available for review by the injured worker, employer and their representatives.

If you have any questions or comments, please contact the BWC claims service specialist listed below.

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date of Signature

Claims Rep:  
(Service Office Name)  
(Service Office Address)  
(Service Office City/St)

Team #:  
Phone #:  
Fax #: