IPRF	WITNESS REPORT – FORM 45-D	IPRF Claims Fax: 888-223-1638 Email: IPRFclaims@ccmsi.com

IPRF Worker's Compensation Witness Report (FORM 45-D)

(To be completed by the witness only)

IPRF Member Agency Name:			
Name of injured employee:			
Name of witness:			
Location where incident occurred:			
Date of incident:		Time of incident:	

1.	What were you (the witness) doing at the time of incident?
2.	How and when did you become aware of the incident?
3.	What did you hear at the time of the incident?
4.	Describe what you saw at the time of the incident:
5.	Who else was present?
6.	Please relate any additional information you have pertaining to the incident:

Witness Signature: _____ Date signed: _____

Forward the completed form to the Worker's Compensation Administrator at. Thank you.