

Witness Statement Form (Form 5)



For Claim by : _____

(To be completed by witness using BLOCK LETTERS)
I, _____
Of (Residential address of
Witness) _____
Employed By : _____ Occupation : _____

*Being an actual eye witness of the disability of
witness _____
* A workmate having knowledge _____
***Strike out whichever is not applicable**

Hereby certify that the particulars hereunder are an accurate description of the occurrence -

I first learnt of this occurrence from _____

(Name) _____ a.m. / p.m. on _____
at : _____

Date of Occurrence : ____/____/____ Time : _____ a. m. / p.m.
Cause of Occurrence (describe fully) _____

The resulting disability (do not describe as injured arm, leg, hand, etc, but state fully the type and position of the disability, for example "cut on left arm, grazed right ankle, burnt back of left hand").

If not an actual eye witness of the occurrence, state fully the source and circumstances from which knowledge of the occurrence was obtained -

Knowing that Section 188 of the Workers Compensation and Assistance Act, 1981 provides that any person who by a false statement or other means, aids or abets a person in a fraudulent attempt to obtain any benefit under the Act is guilty of an offence, I certify that this is a true statement.

Dated at _____ the _____ 19____

Signed _____
in the presence of _____

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