THE CITY OF NEW YORK

WORKERS' COMPENSATION CLAIM INITIATION

WITNESS STATEMENT

FISA FORM WCS-120 (8/00)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER

WITNESS INFORMATION

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER

HOME ADDRESS — STREET LOCATION (INCLUDE APT / FL #)

BORO, CITY OR TOWN — STATE — ZIP — PLUS 4

WORK TEL # (AREA CD)

HOME TEL# (AREA CD)

ARE YOU A CITY EMPLOYEE? ☐ YES ☐ NO

RELATIONSHIP TO INJURED

DATE OF ACCIDENT / INJURY — MONTH — DAY — YEAR

TIME OF ACCIDENT — HOUR : MINUTE ☐ AM ☐ PM

LIST OTHER PERSONS WHO ALSO MIGHT HAVE WITNESSED ACCIDENT

FIRST NAME	M.I.	LAST NAME

ATTACH NAMES OF ADDITIONAL WITNESSES

☐ *CONTINUATION ATTACHED*

DESCRIPTION OF ACCIDENT - INCLUDING LOCATION

☐ *CONTINUATION ATTACHED*

NAME (PLEASE PRINT) — TITLE — TEL.#

SIGNATURE — DATE