Reset Form

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

STREET LOCATION (INCLUDE APT / FL #)

HOME ADDRESS

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

ATTACH NAMES OF ADDITIONAL WITNESSES

☐ *CONTINUATION ATTACHED*

FIRST NAME	M.I.	LAST NAME

DESCRIPTION OF ACCIDENT - INCLUDING LOCATION

☐ *CONTINUATION ATTACHED*

NAME (PLEASE PRINT) | TITLE | TEL.#

SIGNATURE | DATE