OMAG
WITNESS/CO-WORKERS STATEMENT

I, _____ was present at the time that employee
(Witness name)

_____ Was reported to have received an on-the-job injury.
(Injured employee)

I did _____ did not _____ witness the injury that occurred.

The following is a brief description of what I observed on _____ at
(Date)
approximately _____ a.m. _____ p.m. _____.
(Time)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

_____
Witness **Date**

_____
EMPLOYER

SEND ORIGINAL TO:
Consolidated Benefits Resources, L.L.C.
P.O. Box 13770
Oklahoma City, OK 73113
(405) 848-3387
(800) 822-5733 (toll free)
(405) 840-4298 (fax)
(800) 898-6465 (toll free fax)
RETAIN COPY FOR YOUR FILE

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.