SAGINAW CHIPPEWA INDIAN TRIBE
SOARING EAGLE CASINO & RESORT
COMP ONE ADMINISTRATORS INC.

WITNESS REPORT OF INJURY

(TO BE COMPLETED BY THE WITNESS)

Name of the Injured Employee:_____

Describe the incident: (date, time, location, sequence of events, people involved, tools or equipment used, ect.)

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Signed by:_____Date:_____

Address:_____Phone:_____

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