SUPERVISOR'S REVIEW FORM

Submit the form completed in its **entirety** to the workers' compensation coordinator **within 5 days of the injury**.

Employee's Name:	**Employee ID:**
Scheduled Work Hours:	**Employee's classification:**

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work. ☐	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment. ☐	The facts do not indicate this claim of injury was work connected. ☐

Details of injury/accident (who, what, where, when, etc.):

Action Recommended:

Witness:

Continuation and Miscellaneous Comments:

Supervisor's Signature	**Job Title**	**Date**

MANAGER'S REVIEW

Do you concur with first line Supervisor's Review? ☐ **YES** ☐ **NO**

If NO, explain:

Manager's Signature	**Job Title**	**Date**