

SUPERVISOR'S REVIEW FORM

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury. Submit the form completed in its entirety to Safety and Risk Management **within 5 days of the injury.**

Employee's Name:	Employee ID:
Scheduled Work Hours:	Payroll Classification Number:

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work. <input type="checkbox"/>	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. <input type="checkbox"/>	The facts do not indicate this claim of injury was work connected. <input type="checkbox"/>
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Details of injury/accident (who, what, where, when, etc.):

Action Recommended:

Witness:

Continuation and Miscellaneous Comments:

Supervisor's Signature	Job Title	Date
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MANAGER'S REVIEW

**Do you concur with first line
Supervisor's Review?
If NO, explain:**

YES **NO**

Manager's Signature

Job Title

Date