

# **SUPERVISOR'S REVIEW OF WORK-RELATED INJURY REPORT**

**WITHIN 24 HOURS OF NOTICE OR KNOWLEDGE OF ANY INJURY, SUBMIT THE FOLLOWING TO YOUR HUMAN RESOURCE DEPT.**

1. Employee's Report of Injury - completed and signed
2. Signed Certificate Authorizing Release of Medical Information (Workers' Comp. Board Form #220)
3. This Supervisor's Review - completed and signed

1. Name of Injured Employee: \_\_\_\_\_

2. Date of Injury: \_\_\_\_\_ 3. Type of Injury: \_\_\_\_\_

4. Date and Time you received notice, or had knowledge of the injury: \_\_\_/\_\_\_/\_\_\_ \_\_\_\_:\_\_\_\_ am/pm

5. Who informed you? \_\_\_\_\_

6. Person(s) not listed on the Employee's Report who might provide further information about the incident: \_\_\_\_\_

6a. Name and position: \_\_\_\_\_

6b. Work address and phone: \_\_\_\_\_

7. In your review of this Employee's Report of Injury, did you find it complete and accurate?  yes  no

7b. If no, what item or items were missing, incomplete or innacurate? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Was this injury (check only one)  Avoidable  Unavoidable

8b. If avoidable, what could have been done? \_\_\_\_\_

\_\_\_\_\_

9. What corrective measures have or are being taken? \_\_\_\_\_

10. Had this employee been trained in preventing this type of injury?  yes  no

Your Name and Title: \_\_\_\_\_

Your Normal Work Hours: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_