HAMILTON COUNTY INCIDENT REPORT
SUPERVISOR VERIFICATION FORM

The following questions are to be answered by the Injured Worker's (IW) acting supervisor on duty at the time of the incident. Answer with information as you witnessed the incident, ***OR,*** as you determine based on your preliminary investigation**:**

Supervisor Name: _____ **Phone:** _____

Date IW reported the incident to you: _____

IW Name: _____
First MI Last

Site Where IW Normally Works (Address or Building Name): _____

Division: _____ IW's Job Title: _____

Hours IW Normally Works: _____ Days IW Normally Works: _____

Supervisor: Please verify that the following information contained on the First Report of Injury (FROI) is accurate:

1) Date of the incident	☐ YES ☐ NO	2) Time the incident occurred	☐ YES ☐ NO
3) Location of Incident	☐ YES ☐ NO	4) Was the incident work-related	☐ YES ☐ NO
5) Was medical attention sought	☐ YES ☐ NO	6) Did the incident occur on employer's premises	☐ YES ☐ NO
7) Did the incident occur as IW stated	☐ YES ☐ NO	8) Is the exact injury or illness accurately described	☐ YES ☐ NO

List any information that may not be accurate and clarify by explaining what is different or how it is different.

_____

_____

_____

_____

(Please use the back of this page if more room is needed)

9) Were there witnesses to this incident ☐ YES ☐ NO **If yes, answer 9a,** if no skip to 10.

9a) Are the witness statements attached ☐ YES ☐ NO, why not _____

10) Is there any work loss or restricted activity related to this incident? ☐ YES ☐ NO **If yes, answer 10a.**

10a) Record the number of days: Work loss _____ Restricted _____

_____ _____
Supervisor's Signature *Date*

Effective 1/1/2004; revised 9/01/2006

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