



THE INSTITUTE OF

Epidermal Cell Therapy

Date of Accident: _____ Person filling out Report: _____

Name of person injured: _____ Supervisor's Name: _____

(This form is to only be filled out by the supervisor)

Name: _____

What was the diagnosis from the E.R. or Primary Physician?

Is there any follow up needed with the Physician?

Yes No

What is the follow up? _____

Was employee released back to work? Yes No

Did employee miss any work? Yes No

What were the dates of work missed? _____

Signature of Supervisor