**Channel Control Merchants, LLC**

**Dirt Cheap Building Supplies, LLC**

**CCM Support Services, LLC**

**Treasure Hunt, LLC**

**Dirt Cheap, LLC**

**EMPLOYEE ACCIDENT INVESTIGATION FORM**

**To be filled out by Facility Manger and /or Supervisor and Employee:**

(First) (Middle) (Last)

Home Address:

Home Phone: ( ) DOB: M/F CLAIM #

What is your primary language? Can you communicate in English? Yes/No

Date of Report: Witnesses:

Employment Status: PT/FT Temporary Trainee Intern PT/Seasonal Visitor (circle one) Contractor

Wage/Salary: Date of Hire:

Department: Performing Regular Duties at time of Accident? YES/NO

If not, what tasks were being performed at time of injury?

Starting Date at Current Position: Date of Injury: Time of Injury: AM/PM

What was employee doing at time of injury?

Employee instructed in the job? YES NO Date & Time called in:

Doctor’s Visit? YES/NO Date of Doctor’s Visit: Name of Medical Provider:

**Accident Resulted In: (check all that apply)**

\_\_ Injury \_\_ Illness \_\_ Property Damage \_\_ Near Miss \_\_ First Aid \_\_ Doctor Visit \_\_ Lost Time

**TO BE FILLED OUT BY EMPLOYEE:**

**Employee Statement:** In sequence: (1) Part of Body Injured; (2) Your location and position; (3) what job task were you performing? (4) What occurred to trigger the accident? (5) Substance or Object connected with Accident/Illness or Incident.

(1)

(2)

(3)

(4)

(5)

Is this an aggravation of a previous treatment? \_\_\_YES \_\_\_ NO

Have you ever had a similar injury? \_\_\_ YES \_\_\_ NO

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By signing this form, I agree that the above comments, to the best of my knowledge and belief, are true and accurate and describe the cause of and resulting injury. I approve of the release of all medical information to my employer and /or the Insurance Company (representative of employer) as a result of treatment by any physical or medical facility involved with this case. A copy of this form will serve as the original.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnesses: (Print Names, Position, Contact Information)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE FILLED OUT BY SUPERVISOR:**

**DESCRIBE IF ANY, THE UNSAFE ACT, CONDITIONS OR HAZARDS AND ANY UNDERLYING CAUSES OR FAILURES**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMMEDIATE & FUTURE CORRECTIIVE ACTION TAKEN, IF ANY, AND TARGET/COMPLETION DATES: (assigned to whom)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Immediate Supervisors Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

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