

Mine Accident, Injury and Illness Report

U.S. Department of Labor
 Mine Safety and Health Administration



Approved For Use Through 12/31/2004 OMB Number 1219-0007

Section A - Identification Data

MSHA ID Number _____ Contractor ID _____ Report Category
 Metal/Nonmetal Mining Coal Mining Check here if report pertains to contractor

Mine Name _____ Company Name _____

Section B - Complete for Each Reportable Accident Immediately Reported to MSHA

1. Accident Code (circle applicable code - see instructions)
 01 - Death 02 - Serious Injury 03 - Entrapment
 04 - Inundation 05 - Gas or Dust Ignition 06 - Mine Fire 07 - Explosives 08 - Roof Fall
 09 - Outburst 10 - Impounding Dam 11 - Hoisting 12 - Offsite injury

2. Name of Investigator _____ 3. Date Investigation Started _____ 4. Steps Taken to Prevent Recurrence of Accident _____

Section C - Complete for Each Reportable Accident, Injury or Illness

5. Circle the Codes Which Best Describe Where Accident/Injury/Illness Occurred (see instructions)

(a) Surface Location: 02 Surface at Underground Mine 03 Mill, Preparation Plant, etc. 04 Strip/Open Pit Mine 05 Cullm Bank/Refuse Pile 06 Dredge Mining 07 Other Surface Mining 08 Independent Shops (with own MSHA ID) 09 Office Facilities

(b) Underground Location: 01 Vertical Shaft 02 Slope/Inclined Shaft 03 Face 04 Intersection 05 Underground Shop/Office 06 Other

(c) Underground Mining Method: 01 Longwall 02 Shortwall 03 Conventional Stoping 04 Continuous Mining 05 Hand 06 Caving 07 Other

6. Date of Accident _____ 7. Time of Accident • am _____ 8. Time Shift Started • am _____
 _____ • pm _____ • pm _____

9. Describe Fully the Conditions Contributing to the Accident/Injury/Illness, and Quantify the Damage or Impairment

10. Equipment Involved	Type	Manufacturer	Model Number	10
				MAN

11. Name of Witness to Accident/Injury/Illness _____ 12. Number of Reportable Injuries or Illnesses Resulting from This Occurrence _____

13. Name of Injured/ill Employee _____ 14. Sex Male Female _____ 15. Date of Birth _____

16. Last Four Digits of Social Security Number _____ 17. Regular Job Title _____ 18. Check if this Injury/Illness resulted in death. 19. Check if Injury/Illness resulted in permanent disability (include amputation, loss of use, & permanent total disability).

20. What Directly Inflicted Injury or Illness? _____ 21. Nature of Injury or Illness _____

22. Part of Body Injured or Affected _____ 23. Occupational Illness (circle applicable code - see instructions) 21 Occupational Skin Diseases 22 Dust Diseases of the Lungs 23 Respiratory Conditions (toxic agents) 24 Poisoning (toxic Materials) 25 Disorders (physical agents) 26 Disorders (repeated trauma) 29 Other _____

24. Employee's Work Activity When Injury or Illness Occurred	Experience	Years	Weeks
	25. Experience in This Job Title		
	26. Experience at This Mine		
	27. Total Mining Experience		

Section D - Return to Duty Information

28. Permanently Transferred or Terminated (if checked, complete items 29,30, &31) 29. Date Returned to Regular Job at Full Capacity (or item 28) _____

30. Number of Days Away from Work (if none, enter 0) _____ 31. Number of Days Restricted Work Activity (if none, enter 0) _____

Person Completing Form (name) _____ Title _____

Date This Report Prepared (month, Day, year) _____ Area Code and Telephone Number _____

For Official Use Only

Degree _____

Accident Type _____

Accident Class _____

Scheduled Charge _____

Keyword _____
