

# Mine Accident, Injury and Illness Report

## U.S. Department of Labor

Mine Safety and Health Administration



Approved For Use Through 04/30/2008 OMB Number 1219-0007

**Section A - Identification Data**

MSHA ID Number	Contractor ID	Report Category	<input type="checkbox"/> Check here if report pertains to contractor
		Metal/Nonmetal Mining      Coal Mining	
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							
		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Month</td> <td style="width:25%;">Day</td> <td style="width:25%;">Year</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>		Month	Day	Year			
Month	Day	Year							
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	30 Mill, Preparation Plant, etc.	03 Strip/Open Pit Mine	04 Surface Auger Operation
	05 Culm Bank/Refuse Pile	06 Dredge Mining	12 Other Surface Mining	17 Independent Shops (with own MSHA ID)
	99 Office Facilities			
(b) Underground Location:	01 Vertical Shaft	02 Slope/Inclined Shaft	03 Face	04 Intersection
	05 Underground	06 Shop/Office	07 Other	
(c) Underground Mining Method:	01 Longwall	02 Shortwall	03 Conventional Stoping	05 Continuous Mining
	06 Hand	07 Caving	08 Other	

6. Date of Accident	7. Time of Accident • am	8. Time Shift Started • am											
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Month</td> <td style="width:25%;">Day</td> <td style="width:25%;">Year</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Month	Day	Year				• pm	• pm	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:50%; text-align: center;">7</td> </tr> <tr> <td></td> <td style="text-align: center;">8</td> </tr> </table>		7		8
Month	Day	Year											
	7												
	8												

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

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10. Equipment Involved	Type	Manufacturer	Model Number	10 MAN
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11. Name of Witness to Accident/Injury/Illness	12. Number of Reportable Injuries or Illnesses Resulting from This Occurrence
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13. Name of Injured/III Employee	14. Sex	15. Date of Birth							
	• Male • Female	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Month</td> <td style="width:25%;">Day</td> <td style="width:25%;">Year</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Month	Day	Year				12 14
Month	Day	Year							

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).
			16 17 18 19

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

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

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		

<b>Section D - Return to Duty Information</b>								
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)						
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Month</td> <td style="width:25%;">Day</td> <td style="width:25%;">Year</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Month	Day	Year				31. Number of Days Restricted Work Activity (if none, enter 0)
Month	Day	Year						

Person Completing Form (name)	Title
Date This Report Prepared (month, Day, year)	
Area Code and Telephone Number	

For Official Use Only

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Degree

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Accident Type

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Accident Class

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Scheduled Charge

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Keyword

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