

**UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION**

COAL MINE SAFETY AND HEALTH

**REPORT OF INVESTIGATION
(Surface Coal Mine)**

**Fatal Machinery Accident
September 19, 2008**

**East Mac & Nellie Mine
ICG Hazard, LLC
Ary, Perry County, Kentucky
I.D. No. 15-18966**

**Accident Investigator
David A. Faulkner
Surface Coal Mine Health and Safety Inspector**

**Originating Office
Mine Safety and Health Administration
District 7
3837 S. U.S. Hwy. 25 E, Barbourville, Ky. 40906
Irvin T. Hooker, District Manager**

Table of Contents

OVERVIEW	1
GENERAL INFORMATION	1
DESCRIPTION OF ACCIDENT	1
INVESTIGATION OF ACCIDENT	3
DISCUSSION	4
General Machine Information.....	4
ROPS and Seat Belt	4
Transmission.....	4
Braking System Designs.....	5
Service and Parking Brake Controls and Performance Test.....	5
Dozer Work Lights.....	5
Weather Conditions.....	6
Location of Accident.....	6
Local Geologic Setting.....	6
On site Observations and Discussion of Mode of Failure.....	6
ROOT CAUSE ANALYSIS	7
CONCLUSION	8
ENFORCEMENT ACTIONS	9
APPENDIX A - List of persons furnishing information and/or present during the investigation	
APPENDIX B - List of Persons Interviewed	
APPENDIX C - 7000-50b Form	

PHOTOGRAPH OF ACCIDENT SCENE



OVERVIEW

At approximately 1:15 a.m. on September 19, 2008, a fatal machinery accident occurred in the Mac & Nellie cut through area of the ICG Hazard, LLC, East Mac & Nellie mine near Ary, Perry County, Kentucky. Harold Lee Graham, a 53 year old equipment operator with 30 years of mining experience, suffered fatal injuries while operating a Caterpillar D11N bulldozer. Graham was pushing shot material from blasting when the accident occurred. The bulldozer went over an exposed high wall and fell 203 feet.

There were no eyewitnesses to the accident. It is the consensus of the investigation team that a highwall failure occurred suddenly in competent rock while the bulldozer was being operated on the top of the spoil area above the southeast highwall.

GENERAL INFORMATION

The East Mac & Nellie Mine is a surface coal mine located approximately five miles North of the East 80 and 476 Junction on State Route 476 at Ary, Kentucky. The mine, operated by ICG Hazard, LLC produces bituminous coal and employs 79 people. The mine has two production shifts per day and operates six days per week. The coal is mined from three pits with wheel loaders, haul trucks, and bulldozers. The bulldozers assist in both the mining and reclamation processes of this mine. The pit areas are identified as Laurel Fork, Buck Branch, and Mac & Nellie. The mine produces 4,000 tons of coal per day from the Hazard number 7, 8, 9, and 10 coal seams. Independent contractor trucking companies transport the coal from the coal pits to various delivery locations off of the mine site.

The principal officers for ICG Hazard, LLC are:

Greg Feltner	Operations Manager
Rodney Campbell.....	Surface Operations Manager
Tim A. Martin	ICG Corporate Director Health and Safety
Roger L. Neace	Safety Director

The last regular safety and health inspection (E01) conducted by the Mine Safety and Health Administration was completed on September 15, 2008.

DESCRIPTION OF ACCIDENT

On Thursday, September 18, 2008, Harold L. Graham, an equipment operator on the Utility Crew, arrived at the mine parking area at approximately 4:15 p.m. to prepare for his shift that started at approximately 4:30 p.m. Two or three times per week, Graham was asked to come in early to operate the road grader, water truck, or other equipment in preparation for the normal shift. The normal second shift production shift began at 6:00 p.m. and concluded at 4:30 a.m. Graham began the early shift work in the parking area operating the grader and working on the roadways at various mine locations.

At approximately 5:30 p.m., Larry Baker, the second shift lead foreman contacted Graham. He instructed Graham to begin the normal production shift at 6:00 p.m. by operating the Caterpillar D11N bulldozer, Co. No. 1073, in a shot area directly below the No. 10 leader coal seam on the Southwest side of the Mac & Nellie cut through area of the mine. The foreman stated that two other bulldozers would soon arrive from the Buck Branch area of the mine to assist Graham with the same task. The foreman confirmed the correct location of the shot and direction of pushing the shot materials with Graham at the start of the shift. The Caterpillar D11N bulldozer, Co. No. 1073, had been operated approximately 3 to 4 hours by Tommy Ritchie, the day shift bulldozer operator at this location, preparing the roadway and shot area for night shift production.

Graham trammed the bulldozer to the southwest side of the Mac & Nellie cut through. According to blasting shot records, the shot was fired at 11:25 a.m. on September 18, and contained approximately 55,224 cubic yards of material. Graham began pushing materials into the open Hazard No. 7 pit located below the shot. A bulldozer pathway approximately 200 feet in length was created adjacent to the exposed highwall by Graham. Two other Caterpillar D11 bulldozer operators, Eugene North and Gary Hoskins were also directed to work in the area where Graham was working. When North and Hoskins arrived at the site, they found Graham working adjacent to the highwall. They did not communicate to Graham by C.B. radio. North began operating his bulldozer on the outermost pathway, and Hoskins began operating his bulldozer on the middle bulldozer pathway, adjacent to the pathway Graham was working. Because of the work being done by Graham and Hoskins, an area of undisturbed material (wind-row) approximately 11 feet in height was formed between Graham's pathway and the two other bulldozers. The wind-row of material prevented North and Hoskins from seeing Graham's bulldozer. At approximately 11:30 p.m., Russell Meece, another second shift foreman, contacted Graham by C.B. radio requesting the machine service hours. Graham provided the hours on the service meter of the Caterpillar D11N bulldozer.

At approximately 12:30 a.m., Paul Couch, lube truck operator, arrived at the Mac & Nellie cut through along the main travelway located on the Hazard No. 7 rider coal seam elevation adjacent to the open Hazard No. 7 pit into which the three bulldozers were pushing the shot material. Couch called to the three bulldozers operators on the C.B. radio and instructed them to tram to the lower elevation along the roadway for fueling of the bulldozers. North responded, then he and Hoskins left the area where they had been working. As they left the area, they did not see the illumination lights on Graham's bulldozer. Hoskins made one pass down the top of the wind-row between the bulldozer pathways to check for Graham's bulldozer. Both bulldozers continued off the bench to the lower level to refuel and to eat lunch. According to their statements, both Hoskins and North assumed Graham had moved to another area of the mine to perform other work. Meece arrived at the refueling site and asked Hoskins and North about Graham. After this discussion Meece concluded that Graham had not moved to another location. Meece went to the bench elevation where the bulldozers had been working. At approximately 1:15 a.m., Meece traveled to the top of the exposed highwall and used a light to look over the highwall. He observed what appeared to be a bulldozer blade below the highwall. Meece notified lead foreman Larry Baker and the night shift area

manager, Taylor Hignite, of the accident. Meece then instructed Hoskins and North to construct a roadway into the Hazard No. 7 open pit to search for Graham's bulldozer.

At approximately 1:30 a.m., Graham's body and the bulldozer he was operating were located on the Hazard No. 7 pit floor, below the area of the highwall where Graham had been pushing material over. The bulldozer was resting on the right side with the push arms and blade detached. Mine Emergency Technicians (MET) David Bush and Larry Baker checked Graham and found no vital signs. The victim was pronounced dead at 2:32 a.m. September 19, 2008, by Perry County Deputy Coroner, Clayton Brown.

INVESTIGATION OF ACCIDENT

The MSHA call center was notified of the accident at approximately 1:47 a.m. on September 19, 2008. The call center telephoned Dennis Cotton, Supervisory Inspector of the Barbourville, Kentucky field office. Cotton called Roger Neace, Safety Director for ICG Hazard, LLC, who stated that the accident had resulted in a fatality. Cotton then called Marvin Hoskins, Supervisory Inspector at the Hazard field office. Hoskins contacted Inspector John Dishner and dispatched him to the accident site. Dishner traveled to the site and issued a 103(k) order at 3:15 a.m. to ensure the safety of the miners and to preserve the accident scene.

MSHA personnel from the Hazard and Barbourville offices traveled to the accident scene where preliminary information was gathered and the accident scene was examined.

Personnel from MSHA's Approval and Certification Center, including Fred T. Marshall, Mechanical Engineer from the Mechanical & Engineering Safety Division, along with Dai S. Choi, Civil Engineer, from the Mine Waste and Geotechnical Division, were also dispatched to assist with the investigation.

Formal interviews were conducted on September 20, 2008. None of the persons interviewed requested that their statements be kept confidential. For a list of those who participated in the interviews see Appendix B.

DISCUSSION

Interviews were conducted with mine personnel who were determined to have potential information related to the prior operational condition and maintenance of the Caterpillar Model D11N bulldozer. Based upon statements obtained during these interviews, no mechanical problems were reportedly experienced with the bulldozer prior to or on the shift of the accident. The bulldozer operator that operated the bulldozer during the day shift stated that he did not have any problems with the steering or brakes. He stated that he built the road to the bench (victim's work area) during the day shift prior to the accident and that he had stopped on steep grades and steered the bulldozer on steep grades. The finished road area was examined and it was estimated that the day shift operator would have been operating the bulldozer on grades of at least 30 percent while building this road.

The day shift bulldozer operator also stated that all the bulldozer's lights functioned when he did his pre-operational inspection. He stated, however, that he turned the lights off during his shift because it was daylight when he began work, and that he did not perform any type of post-shift inspection of the bulldozer. He also indicated there were no defects with the cab glass that affected the visibility from the operator's cab.

General Machine Information

The bulldozer involved in the accident was a 1990 Caterpillar D11N track-type tractor, serial number 74Z00763 equipped with a Roll Over Protective Structure (ROPS), an enclosed cab with a Falling Object Protective Structure (FOPS), a Caterpillar 3508 diesel engine having a gross power rating of 817 horsepower at 1,800 RPM, a power shift transmission with three speeds in both forward and reverse directions, a Universal bulldozer blade (U-blade) and rear counterweights. The bulldozer was estimated to weigh approximately 199,000 pounds including blade and counterweights.

The bulldozer had an overall length of approximately 29 feet and an overall height of approximately 15 feet with a blade approximately 20 feet, 10 inches wide at the end bits and 7 ¾ feet tall. The bulldozer had 28 inch wide shoes and a track width of 11 feet, 10 inches, as measured from the outside edges of both tracks.

ROPS and Seat Belt

The bulldozer was equipped with a ROPS and a lap-type seat belt with 3 inch wide webbing. The ROPS was intact, but was deformed from impact damage. The seat belt was found latched with the webbing severed near the latch plate. The seat belt's latching mechanism functioned when tested.

Transmission

The transmission was a Caterpillar powershift transmission (an automatic type transmission) with three forward speeds and three reverse speeds. The transmission control in the operator's cab was found in the 1st gear, forward position. During the field investigation, the cover plate for the transmission's hydraulic control valve was removed and it was confirmed that the valve spools for the transmission's hydraulic controls were

in the 1st gear, forward position. Table No. 1 shows the maximum speeds stated in Caterpillar product information.

Gear	Forward Speed (MPH)	Reverse Speed (MPH)
1 st	2.4	2.9
2 nd	4.4	5.1
3 rd	11.6	8.8

Table No. 1: Maximum Travel Speeds At Rated Engine RPM.

Tests indicated that the transmission's selector lever and hydraulic control valve moved throughout all the gear positions with no sticking or binding.

Braking System Designs

The service brake and parking brake systems consisted of spring-applied, hydraulic-released enclosed wet disc brakes on both the right and left side track drives. The parking and service brake systems share the same brake packs at the track drives but are actuated with different controls. The service brake is actuated by a foot pedal and modulates the brake release pressure to both brakes according to the foot pedal position. The parking brake is actuated by a hand control lever, fully applying and releasing both brakes. When either of these two controls is used, both the left and right side brakes apply and release together.

Service and Parking Brake Controls and Performance Test

The service brake foot pedal and linkage was intact, moved throughout its range without sticking or binding and spring returned when released.

The parking brake control lever and linkage was intact and cycled into and out of the "applied" and "released" positions without sticking or binding. The parking brake control lever was found in the "released" position.

The performance of the parking brake/service brake was tested by pulling it with another Caterpillar D11 bulldozer. Both the left and right side tracks remained locked and skidded on the ground when the bulldozer was pulled with the spring-applied brakes engaged.

Dozer Work Lights

It was determined that all three light switches for the bulldozer's work lights (side, front and rear) were in the on position during initial inspection. The electrical control system for the track lights was tested and it was determined to be functional from the battery connections to each of the two track lights (right and left side track lights), however; the lights themselves did not illuminate when tested. The bulbs for these two lights were removed and visually inspected. The light filaments for both of these bulbs were not burnt, but were physically broken, consistent with failure due to impact damage.

Weather Conditions

Recap of the conditions around 1:00 a.m. (11:53 p.m. to 1:53 a.m.) on Friday, September 19, 2008, at the Jackson, Kentucky Weather Station -- visibility was ten miles through the entire period.

Location of Accident

The top bench of the mine is at the elevation of 1,390 feet. This level is the Hazard 10L coal seam horizon and has been stripped over the working area. The bulldozer was working on the 1,329 foot Safety Bench, which was a level below the Hazard 10L coal seam. The pit floor, where the fallen bulldozer came to rest, is at the Hazard No. 7 coal seam level, elevation 1,132 feet.

The bulldozer involved in the accident was operating at the foot of the highwall between the 1,329 foot Safety Bench and the 10L Coal Seam Bench. At the time of the accident, two other bulldozers were operating on the 1,329 foot Safety Bench pushing shot rock over the crest of the southeast highwall. The operators of these bulldozers did not observe the accident because an 11-foot-high wind-row was present between the two working areas.

Local Geologic Setting

The rock above the Hazard No. 7 coal seam consists of sandstone, shale, and additional coal seams. The coal seams above the Hazard No. 7 seam are the Hazard No. 8 seam at the elevation of 1,185 feet, the Hazard No. 9 seam at the elevation of 1,276 feet and the Hazard 10L seam at elevation 1,390 feet. Thin shale formations are found near these coal seams. The sandstone formations above the Hazard No. 7 coal seam are prominent and competent, but fail along existing joints. These formations can be seen in the current highwalls.

On site Observations and Discussion of Mode of Failure

The highwall below the 1,329 foot Safety Bench and above the 1,232 foot Safety Bench had been shot on June 26, 2008 and June 30, 2008. The drilling and blasting plan, along with observations, indicated that pre-split controlled blasting techniques were being used for the highwall. The spacing between pre-split holes was 9 feet. However, no pre-splitting was conducted for the highwall above the 1,329 foot Safety Bench and below the 10L bench on September 18, 2008. This highwall was very broken near the area where the bulldozer was operating.

The thickness of shot overburden at the time and location where the bulldozer went over the highwall was approximately 7 feet. At the location where the bulldozer went over the highwall, an arc shaped scarp (a steep slope or cliff at the edge of a plateau or ridge) was observed within the shot rock. The arc had a length along the crest direction of the highwall of 40 feet. This length was measured using a laser range finder from the 1,329 foot Safety Bench. The depth of arc, perpendicular to the crest, was estimated to be 15 feet within the 7-foot-thick shot rock.

Based on these same marks, the width of the failed area was identified as wider than four pre-split drill holes. The pre-split holes were drilled on a 9-foot interval. This observation confirms the measurement of the laser range finder.

The marks of the left track of the bulldozer involved in the accident were examined on September 20, 2008. The marks of the right track near the failed area were covered with shot rock which had rolled down from highwall since the accident. The track marks clearly extended to the edge of the failed area without any skid marks. The last track mark was visible below the failed area indicating that the bulldozer first tilted and rolled suddenly. The track marks indicated that the bulldozer operator did not have time to react to the sudden tilt of the bulldozer, since no skid marks were observed.

The first scratch marks of the bulldozer on the highwall are found at the bottom of the failed area. The width of the marks corresponds to that of the bulldozer's cabin. This would further indicate that the bulldozer rolled down from the top of the failed area during the initial stage of fall.

At the time of the accident, the bulldozer was not operating perpendicular to the southeast highwall. Due to over-break of the highwall above the 1329 foot Safety Bench, the operator had turned the bulldozer slightly around the southeast corner of the highwall above 1329 feet.

ROOT CAUSE ANALYSIS

An analysis was conducted to determine the most basic causes of the accident that were correctable through reasonable management controls. During the analysis a causal factor was identified that, if eliminated, would have either prevented the accident or mitigated its consequences. Below is the causal factor identified during the analysis and the corresponding corrective action implemented to prevent a recurrence of the accident.

Causal factor: The standards, policies and procedures used by the mine operator did not ensure that safe working conditions were provided for the employees at all times. The bulldozer was not operated a safe distance from the edge of the exposed highwall while pushing material over the edge.

Corrective actions: The mine operator developed a plan to prevent a similar occurrence of this accident. The ground control plan was revised to show that equipment used to remove material over elevated highwalls will be required to use the double blade method of pushing (one blade of material will be left at the edge and pushed over with the following blade of material). This will allow the machine to remain a safe distance from the edge of the highwall at all times. The plan also requires training to be provided to the employees concerning the revised ground control plan and hazards associated with operating equipment while pushing materials over the edge of highwalls.

CONCLUSION

At the time of the accident, the bulldozer was not operating perpendicular to the southeast highwall. Due to over-break of the highwall above the 1329 foot Safety Bench, the operator had turned the bulldozer slightly around the southeast corner of the highwall. The investigation revealed that a highwall failure occurred suddenly in competent rock when the bulldozer was operating on the top of the spoil area above the southeast highwall. The track marks indicated that the bulldozer operator did not have time to react to the sudden tilt of the bulldozer since no skid marks were observed.



Irvin T. Hooker
District Manager

3/18/2009

Date

ENFORCEMENT ACTIONS

Order No. 7534095 was issued to ICG Hazard, LLC on September 19, 2008, under the provisions of Section 103(k) of the Mine Act:

The mine has experienced a fatal accident in the Mac and Nellie cut through area of the mine. A bulldozer has fallen from the 10 seam level to the 7 seam level. This Order is issued to ensure the safety of any person in the coal mine until an examination or investigation is made to determine that the Mac and Nellie cut through area including the 10 seam bench to the 7 seam pit is safe. Only those persons selected from company officials, state officials, the miners' representative and other persons who are deemed by MSHA to have information relevant to the investigation may enter or remain in the affected area.

The operator was required to revise the Ground Control Plan to include procedures that will be followed when pushing materials from elevated highwall edges.

1. The mine operator was required to provide training to bulldozer operators on recognizing pushing material hazards, taking appropriate corrective measures and using safe pushing procedures.
2. Before anyone is assigned to push materials over a highwall the wall will be inspected for cracks or hill seams.
3. All equipment used to remove materials over highwalls will be required to use the double blade method of pushing (one blade of material will be left at edge and pushed over with the following blade of material.) This will allow the machine to remain a safe distance from the edge of the highwall at all times.

APPENDIX A

List of persons furnishing information and/or present during the investigation

ICG Hazard, LLC Officials

Tim A. Martin ICG, Corporate Director Health and Safety
Greg Feltner Operations Manager ICG Hazard, LLC
Rodney Campbell..... Surface Operations Manager, ICG Hazard, LLC
Roger Neace..... Safety Department
Taylor Hignite..... Area Manager/Night
Eugene Robertson Area Manager/Day
Nolan Fraley..... Superintendent
Larry Baker Lead Foreman/Night
James Sizemore..... Lead Foreman/Day
Russell Meece Foreman/Night
James Cox Maintenance Manager
Melanie J. Kilpatrick..... Attorney at Law

ICG Hazard, LLC/East Mac & Nellie -Employees

David Anderson Bush..... Rock truck driver & Met second shift
William R. Mullins Utility-man
Paul Douglas Couch..... Mechanic/lube-fuel truck operator
Gary Michael Hoskins Dozer operator second shift
Eugene North Dozer operator second shift
Tommy Ritchie Dozer operator first shift
Michael Combs Blaster day shift

Kentucky Office of Mine Safety & Licensing

Tracy Stumbo..... Chief Accident Investigator
Greg Goins Deputy Chief Accident Investigator
Tim Fugate..... Accident Investigator
Neil Honeycutt..... Surface Safety Analysis

Mine Safety and Health Administration

David A. Faulkner..... CMS&H Surface Inspector/Accident Investigator
Dennis J. Cotton..... Supervisory CMS & H/Accident Investigator
Larry W. Stubblefield CMS&H Surface Inspector
John Boylen CMS&H Inspector/ Accident Investigator
Robert Ashworth..... CMS&S Inspector/Accident Investigator
John W. Dishner..... CMS&H Inspector
Deborah B. Combs..... Educational Field Services
Dai S. Choi..... Mechanical Engineer, Mechanical Safety Division
MSHA Approval and Certification Center
F. Terry Marshall Mechanical Engineer, Mechanical Safety Division
MSHA Approval and Certification Center
Thomas Grooms..... Office of the Solicitor-Nashville
Ronnie L. Brock..... District 7 Accident Investigation Coordinator

Other Personnel

Clayton Brown..... Perry County Deputy Coroner

APPENDIX B
List of Persons Interviewed

David Anderson Bush.....Rock truck driver & MET second shift
William R. MullinsUtility Man
Paul Douglas Couch.....Mechanic/fill in lube-fuel truck operator
Gary Michael Hoskins Dozer Operator second shift
Eugene North Dozer Operator second shift
Tommy RitchieDay Shift bulldozer Operator (Informal Interview)
Russell MeeceSecond Shift Foreman
Larry BakerSecond Shift Foreman
Roger Neace..... Safety Director

APPENDIX C

MSHA Form 7000-50b

Accident Investigation Data - Victim Information

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



Event Number: 4 4 4 5 1 0 9

Victim Information: 1																			
1. Name of Injured/Ill Employee: <i>Harold L. Graham</i>				2. Sex: <i>M</i>		3. Victim's Age: <i>53</i>		4. Degree of Injury: <i>01 Fatal</i>											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 09/19/2008 b. Time: 2:32</i>								6. Date and Time Started: <i>a. Date: 09/18/2008 b. Time: 16:30</i>											
7. Regular Job Title: <i>168 Bulldozer/tractor operator</i>				8. Work Activity when Injured: <i>047 Operating Bulldozer</i>				9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
10. Experience		Years	Weeks	Days	b. Regular		Years	Weeks	Days	c. This		Years	Weeks	Days	d. Total		Years	Weeks	Days
a. This					Job Title:					Mine:					Mining:				
Work Activity:		<i>30</i>	<i>0</i>	<i>0</i>	<i>30 0 0</i>		<i>1 0 0</i>		<i>30 0 0</i>		<i>30 0 0</i>								
11. What Directly Inflicted Injury or Illness? <i>076 Surface mining machines</i>										12. Nature of Injury or Illness: <i>370 Multiple injuries</i>									
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>																			
14. Company of Employment: (If different from production operator) <i>Operator</i>														Independent Contractor ID: (if applicable)					
15. On-site Emergency Medical Treatment: Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>																			
16. Part 50 Document Control Number: (form 7000-1)								17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>											

Victim Information:																			
1. Name of Injured/Ill Employee:				2. Sex:		3. Victim's Age:		4. Degree of Injury:											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:								6. Date and Time Started:											
7. Regular Job Title:				8. Work Activity when Injured:				9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/>											
10. Experience		Years	Weeks	Days	b. Regular		Years	Weeks	Days	c. This		Years	Week	Days	d. Total		Years	Weeks	Days
a. This					Job Title:					Mine:					Mining:				
Work Activity:																			
11. What Directly Inflicted Injury or Illness?										12. Nature of Injury or Illness:									
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>																			
14. Company of Employment: (If different from production operator)														Independent Contractor ID: (if applicable)					
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>																			
16. Part 50 Document Control Number: (form 7000-1)								17. Union Affiliation of Victim:											

Victim Information:																			
1. Name of Injured/Ill Employee:				2. Sex:		3. Victim's Age:		4. Degree of Injury:											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:								6. Date and Time Started:											
7. Regular Job Title:				8. Work Activity when Injured:				9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/>											
10. Experience		Years	Weeks	Days	b. Regular		Years	Weeks	Days	c. This		Years	Week	Days	d. Total		Years	Weeks	Days
a. This					Job Title:					Mine:					Mining:				
Work Activity:																			
11. What Directly Inflicted Injury or Illness?										12. Nature of Injury or Illness:									
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>																			
14. Company of Employment: (If different from production operator)														Independent Contractor ID: (if applicable)					
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>																			
16. Part 50 Document Control Number: (form 7000-1)								17. Union Affiliation of Victim:											