

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION
(Surface Area of Underground Coal Mine)

Fatal Accident (Powered Haulage)
October 9, 2009

Isaac Nathaniel Cox/DBA
Cox Trucking (ID V865)
Wartburg, Tennessee

at
Mine 5A
National Coal Corporation
Devonia, Anderson County, Tennessee
I.D. No. 40-03328

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

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PHOTOGRAPH OF ACCIDENT SCENE



OVERVIEW

At approximately 8:30 a.m. on October 9, 2009, Darrell T. Seiber (victim), a 48-year old truck driver for Cox Trucking, with 21 days of experience at this mine, was fatally injured while operating a loaded DM-886SX Mack tandem axle coal truck. The truck accident occurred along the National Coal Corporation, Mine 5A, underground mine haul road. Seiber lost control of the overloaded truck causing the truck to leave the roadway, traveling into the left side drainage ditch, striking the embankment and a small poplar tree, then over turning. Seiber apparently attempted to jump or was thrown from the truck. There were no eyewitnesses to the accident. The accident occurred because the contractor and mine operator failed to make certain that defects affecting safety were corrected before the truck was put in service. Failure of the contractor and mine operator to assure the driver maintained control of the overloaded truck while descending the mine haul road also contributed to the accident. The victim was not wearing a seat belt at the time of the accident. The contractor failed to ensure that the victim had received required training.

GENERAL INFORMATION

National Coal Corporation, Mine 5A, is a one-unit underground coal mine with a continuous haulage system, mining the Windrock coal seam, located approximately 4 miles off State Route 116S at Devonia, Tennessee. The mine operates two eight-hour production shifts and one maintenance shift, five days per week, employing 53 miners. The mine produces approximately 2000 tons of raw coal per day. National Coal Corporation hires contract coal haulers. The coal hauler trucks use tandem or tri-axle dump trucks to transport the mine-run coal stockpiled at the Mine 5A portal to National Coal Corporation's Preparation Plant No. 3, located at Smoky Junction in Scott County. The total driving distance from the mine to the preparation plant is about 14 miles.

The principal officer for National Coal Corporation is:

Daniel A. Roling President/CEO

Cox Trucking (MSHA Contractor I.D. V865), located at Wartburg Tennessee, is an independent trucking contractor having one coal truck and one employee.

The principal officer for Cox Trucking is:

Isaac Nathaniel Cox Owner

Prior to the accident, the Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection on September 30, 2009. The Non-Fatal Days Lost (NFDL) injury incidence rate for the mine through the 2nd Quarter of Calendar Year 2009 was 19.18, compared to a National NFDL rate of 4.27.

DESCRIPTION OF ACCIDENT

On Friday, October 9, 2009, at approximately 6:00 a.m., Darrell T. Seiber, a coal truck driver employed by independent contractor, Cox Trucking, arrived at the National Coal Corporation, Mine 5A and stockpile area to haul coal. Seiber was operating a 1982 DM886SX Mack tandem axle coal truck, S/N 1M2B156CXCA002840. The normal mine production shift begins at 7:00 a.m. with the operator of the coal loader starting to load coal trucks at 6:00 a.m. Seiber was the first truck to load on this shift and transported his first load of coal to the National Coal Corporation Preparation Plant No. 3. Seiber dumped his first load at 6:56 a.m. then proceeded back to the mine, loaded his second load and returned to dump at 7:54 a.m. Seiber returned to the mine, obtained his third load and traveled along the mine haul road to the portion of the road where the accident occurred. At approximately 8:30 a.m., Seiber lost control of the loaded Mack coal truck while attempting to negotiate a curve to the left and descending the steep downhill grade. The truck entered the left side drainage ditch along the haul road, traveled approximately 40 feet, striking the embankment and a small 8 to 10 inch diameter poplar tree, at which time Seiber appears to have attempted to jump or was ejected from the truck. The truck then exited the drainage ditch, re-entered the roadway briefly and overturned onto the truck's left side into the drainage ditch.

Richard Cox, foreman at the National Coal Corporation Preparation Plant, left the 5A Mine face-up area in his pick-up truck approximately two minutes after Seiber had loaded and left the coal stockpile area. Cox stated that he had brought the motor grader operator to the mine and fueled the motor grader, which had been left on site the previous shift. Cox stated that he drove normally and only briefly saw the rear of the Seiber's truck from a distance as it started down the steep incline known as the "flag pole." Cox stated that when he started to descend the grade, Seiber's truck was "no where to be seen." Cox proceeded down the incline and came upon the overturned truck. Cox immediately called for help on the C.B. radio and notified other trucks in the vicinity that an accident had occurred, warning the other trucks not to start down the incline. Cox found Seiber lying prone in the four-foot deep drainage ditch, directly behind the overturned truck.

Cox's call for help was heard by Randy Overton, Loader Operator, at the Mine 5A, who notified Assistant Mine Supt., Ricky Cook. Employee Brandon Fricke was sent by Cook to the accident scene with a first aid kit. Cook also notified Safety Inspector, Ronald Massengale and Safety Director, Don McDaniel of the accident then quickly proceeded to the accident scene himself. National Coal Corporation personnel at the Preparation Plant No. 3 called the Anderson County 911 emergency number.

Hearing the call for help, Keith McKamey, an independent contract coal truck driver, who was descending the haul road in front on Seiber, parked his truck and returned to

the accident scene with truck driver James Lay. Upon arrival at the scene McKamey checked Seiber and found a pulse, although he was unconscious and non-responsive. Seiber was repositioned from the drainage ditch onto the roadway where rescue breathing was attempted by McKamey for approximately twenty minutes until a pulse was no longer found. Brandon Fricke, assisted by Ricky Cook and Ronald Massengale, began CPR at this time and continued until the arrival of the Anderson County Ambulance Service at approximately 9:32 a.m. Seiber was transported to the University of Tennessee Medical Center where he was dead on arrival.

INVESTIGATION OF ACCIDENT

At approximately 8:47 a.m. on Friday, October 9, 2009, Kevin Bruner, Supervisory Coal Mine Safety and Health (CMS&H) Inspector from the MSHA Jacksboro, TN Field Office, was notified by Don McDaniel, Safety Director for National Coal Corporation, of a serious haulage accident that had occurred along the Mine 5A haul road. A verbal 103(j) Order was issued to ensure the safety of the miners and to preserve the accident scene. Bruner contacted Ronald W. Burns, Acting Assistant District Manager, informed him of the accident and proceeded to the mine. Burns notified Irvin T. Hooker, District Manager, and Jim Langley, Assistant District Manager, of the accident. Edward F. Taylor, CMS&H Inspector/Accident Investigator was notified by Burns of the accident and dispatched to the accident scene. Langley and David A. Faulkner, CMS&H Inspector/Accident Investigator, traveled to the Jacksboro Field Office. They were briefed and escorted to the mine site by Clayton E. Sparks, Supervisory CMS&H Inspector of the Barbourville, KY Field Office.

The 103(j) Order was modified to a 103(k) Order to protect the safety of all persons on site, including those involved in the recovery operations or investigation of the accident.

MSHA accident investigators, along with the Tennessee Highway Patrol, gathered preliminary information and conducted an investigation of the existing physical conditions. Photographs and relevant measurements were taken.

MSHA's Technical Support Division assisted with the investigation. Eugene D. Hennen, Mechanical Engineer from the Mechanical & Engineering Safety Division and Paul J. Donahue, Civil Engineer from the Mine Waste & Geotechnical Engineer Division arrived on October 10, 2009.

Formal interviews were conducted on October 14, 2009, at the MSHA field office at Jacksboro, TN. None of those interviewed requested that their statements be kept confidential. For a list of those who participated in the interviews see Appendix B.

A non contributory citation was issued for a failure to comply with 30 CFR, § 50.10, which requires a mine operator to contact the MSHA call center at once, without delay, and within 15 minutes. The MSHA Hotline was notified of the accident at 10:28 a.m. on October 9, 2009.

The physical portion of the investigation was completed on October 16, 2009, and the 103(k) Order was terminated.

DISCUSSION

PHYSICAL FACTORS:

- 1) MACHINE INFORMATION - The truck involved in the accident was manufactured in 1981 and registered as a 1982 Mack DM886SX, which had a maximum gross vehicle weight rating (GVWR), as equipped, of 83,000 pounds. Weigh scale tickets at the preparation plant indicated that the truck delivered 50.50 and 40.81 net tons of coal in two previous trips on the day of the accident. The empty weight for these trips was 39,100 pounds, and 39,900 pounds, for gross vehicle weights of 140,100 pounds and 121, 520 pounds, respectively. Therefore, this truck was operating at loads as high as 169% of manufacturer's GVWR.
- 2) ENGINE BRAKE - The truck engine was equipped with a three-stage Jacobs Vehicle Equipment Company engine brake (Jake brake). The dash mounted control had two toggle switches. One toggle switch had two positions for turning the Jake brake on and off. The other toggle switch had three positions for each of the stages of the Jake brake. In addition to the dash switch, the Jake brake system had two additional controls. One of the controls was connected to the clutch pedal. The other switch was connected into the accelerator system. This switch would engage the Jake brake when the accelerator was not being depressed, which would normally be the position of the accelerator as the truck descended a grade.

When investigators first entered the truck after the accident, the "on-off" Jake brake switch was found in the off position, and the "three-position" Jake brake switch was found in the second position. Evaluation of the Jake brake system showed that the Jake brake accelerator switch did not function because part of the engine mounted mechanism for operating the accelerator switch was missing. With this component missing, the Jake brake would not engage when the operator released the accelerator pedal. A test was conducted to determine if the solenoids that controlled the Jake brake heads mounted on the engine were functioning. When the toggle switch was placed in the first position, one of the solenoids engaged, as designed. When the toggle control was placed in the second position, two of the solenoids engaged, as designed. When the toggle was placed in the third position, the third solenoid did not engage.

- 3) TRANSMISSION - The truck involved in the accident had an Eaton fifteen speed transmission. There were five gears in the shifting pattern. The transmission had a high and low range controlled by a switch on the front of the transmission shift lever. A switch on the side of the shift lever could be used to put the transmission into a lower gear ratio, known as the deep reduction mode. The output shaft of the transmission could not be turned, indicating the transmission was in gear. When the investigation team was able to enter the cab, the gear shift lever was found to be in sixth gear. Evaluation of the transmission's high-low range and the deep reduction switch showed they both functioned.
- 4) BRAKE COMPONENT EXAMINATION - All of the brake drums were removed, the inside diameters of the drums were measured, and the brake assemblies closely examined. The brake pushrod strokes were measured using an air system pressure of approximately 100 pounds per square inch (psi). The brakes on all wheels were found to be operative.
- 5) STEEP DESCENDING GRADES - The steep grades on this haul road were the most significant road-condition-related contributing factors. In general, when over-the-highway trucks are operated on grades steeper than 10%, there is little or no margin for recovery of control in the event of mechanical driveline failures, retarder (Jake brake) failure, inappropriate gear or Jake brake settings, or other operator errors or equipment failures. This results in only the service brakes being available to regain control of the truck. Service brakes alone are unlikely to have been sufficient to regain control of the truck on the observed 15% or steeper grade, particularly in the overloaded condition under which this truck was being operated.
- 6) SEAT BELT - The right side of the seat belt was found stored behind the operator's seat with the left side secured behind the lumbar handle on the rear of the seat. This evidence indicated that the seat belt was not in use or had not been used for some time. When tested, the seat belt was firmly attached to the seat with the buckle operating properly.
- 7) PRE-OPERATIONAL CHECK - The investigation interviews revealed that the contractor did not have a policy in place to ensure that equipment safety defects were corrected prior to equipment use. No record of a pre-operational examination was found or made available during the investigation.
- 8) TRAINING - Inspection of company training records and interviews revealed that the victim was an untrained miner. No records have been provided or made available to indicate that the 24 hour initial miner training had been received by Mr. Seiber.
- 9) WEATHER - Weather data was obtained from three locations in the site region: Knoxville, Tennessee (McGhee-Tyson Airport), Crossville, Tennessee, and Mount Vernon, Kentucky. Conditions at each of these stations at the time of the accident were overcast with temperatures in the lower to upper 60 degree (Fahrenheit) range.

All three stations reported a period of light rain before or during the accident. The road where the accident occurred was wet at the time of the accident. However, this is not likely to have affected traction significantly for a loaded truck on the observed crushed-stone road surface.

ROOT CAUSE ANALYSIS

An analysis was conducted to identify the most basic causes of the accident that were correctable through reasonable management controls. During the analysis, root causes were identified that, if eliminated, would have either prevented the accident or mitigated its consequences. The following root causes were identified during the analysis and their corresponding corrective actions intended to prevent a recurrence of the accident:

1. *Root Cause:* Management failed to ensure that new employees have received the proper required training when hired and before assignment of duties.

Corrective Action: Management shall assure that all newly hired employees have received and are aware of the training requirements for all newly hired miners.

2. *Root Cause:* The victim was not wearing a seat belt when he lost control and the truck turned over.


Corrective Action: Drivers shall be instructed that seat belts must be worn at all times when operating mobile equipment.

3. *Root Cause:* Management did not have a policy in place to ensure that equipment safety defects were corrected prior to equipment use.

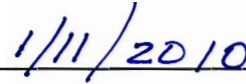
Corrective Action: Management shall establish a written procedure to assure that adequate pre-operational checks are conducted on mobile equipment and to assure that any safety defects identified are corrected prior to operation.

CONCLUSION

The accident occurred because the contractor and mine operator failed to assure that defects affecting safety were corrected before the truck was put in service. Failure of the contractor and mine operator to assure the driver maintained control of the over loaded truck while descending the mine haul road also contributed to the accident. The victim was not wearing a seat belt at the time of the accident. The contractor and mine operator also failed to ensure that the victim has received required training. An untrained miner is a hazard to himself and to others.



Irvin T. Hooker
District Manager



Date

ENFORCEMENT ACTIONS

Order No. 8400466 was issued verbally to National Coal Corporation on October 9, 2009, under the provisions of Section 103(j) of the Mine Act:

An accident occurred at this location on 10/09/2009, at approximately 8:30 a.m. This order is being issued, under section 103(j) of the Federal Mine Safety and Health Act of 1977, to prevent the destruction of any evidence which would assist in investigating the cause or causes of the accident. It prohibits all activity in the area of the haulage road leading to the mine, approximately 1.7 miles from the main highway, until MSHA has determined that it is safe to resume mining operations in this area. This order was initially issued orally to the mine operator at 08:47 hours and has now been reduced to writing.

Modified to 103(k) Order at 10:05 hours.

Citation No. 8356174 issued to Isaac Nathaniel Cox/DBA Cox Trucking (ID V865), 30 CFR, § 48.25:

As a result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, and based on the testimony obtained and the failure to provide or obtain records, it has been determined that Darrell Seiber, (victim), failed to receive the initial miner training as required. The victim was employed as a coal truck driver for Cox Trucking from 09-18-2009 until 10-09-2009, the day of accident. Evidence gathered during the interview portion of the investigation revealed that the owner knew that training was required, but failed to ensure that the victim had received the required initial miner training. The Federal Mine Safety and Health Act of 1977 states that an untrained miner is "a hazard to himself and to others."

Citation No. 8356175 issued to Isaac Nathaniel Cox/DBA Cox Trucking (ID V865), 30 CFR, § 77.1607(b):

As a result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, it has been determined that the truck operator failed to maintain control of the 1982 Blue DM-800 Mack tandem axle coal truck, Model DM886SX, S/N 1M2B156CXCA002840, while the loaded truck was descending the mine haul road. Mobile equipment operators shall have full control of the equipment while it is in motion.

Citation No. 8356176 issued to Isaac Nathaniel Cox/DBA Cox Trucking (ID V865), 30 CFR, § 77.1710(i):

As the result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, and a thorough examination of the Blue DM886SX Mack tandem axle coal truck, S/N 1M2B156CXCA002840, evidence indicated that the seat belt was not in use at the time of the accident. The right side of the seat belt found stored behind the operator's seat with the left side secured behind the lumbar handle on the rear of the seat. When tested the seat belt was firmly attached to the seat with the buckle operating properly. Seat belts shall be worn where the danger of overturning exists.

Citation No. 8356177 issued to Isaac Nathaniel Cox/DBA Cox Trucking (ID V865), 30 CFR, § 77.1606(c):

As the result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, and a thorough examination of the Blue DM886SX Mack tandem axle coal truck, S/N 1M2B156CXCA002840, the following defects affecting safety were found to exist on the truck at the time of the accident: (1) The Jacobs (Jake) engine brake accelerator switch did not function because part of the engine mounted mechanism for operating the accelerator switch was missing. With this component missing, the Jake Brake would not engage when the operator released the accelerator pedal. (2) One of the three Jacobs engine brake solenoids failed to engage or function as required, reducing performance and the capacity of the engine brake. Evidence indicated that these conditions have existed for more than one shift without being corrected.

Citation No. 8356178 issued to National Coal Corporation, 30 CFR, § 77.1606(c).

As the result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, and a thorough examination of the Blue DM886SX Mack tandem axle coal truck, S/N 1M2B156CXCA002840, the following defects affecting safety were found to exist on the truck at the time of the accident: (1) The Jacobs (Jake) engine brake accelerator switch did not function because part of the engine mounted mechanism for operating the accelerator switch was missing. With this component missing, the Jake Brake would not engage when the operator released the accelerator pedal. (2) One of the three Jacobs engine brake solenoids failed to engage or function as required, reducing performance and the capacity of the engine brake. Evidence indicated that these conditions have existed for more than one shift without being corrected.

Citation No. 8356179 issued to National Coal Corporation, 30 CFR, § 50.10:

At approximately 8:45 hours on the morning of 10-09-2009, the mine safety director phoned the MSHA Jacksboro field office supervisor to report a serious truck accident on the mine haul road at the company's Mine 5A. The operator failed to contact the MSHA Hotline immediately at the toll-free number, 1-800-746-1533 without delay and within 15 minutes after the operator knew that an accident had occurred, as required. The MSHA Hotline call center was notified at 10:28 a.m.

Citation No. 8356180 issued to National Coal Corporation, 30 CFR, § 48.25:

As a result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, it has been determined that the mine operator failed to ensure that all persons working on mine property were properly trained. Darrell Seiber, (victim), failed to receive the initial miner training as required. The victim was employed as a coal truck driver for Cox Trucking (V865) from 09-18-2009 until 10-09-2009, the day of accident. The Federal Mine Safety and Health Act of 1977 states that an untrained miner "is a hazard to himself and to others."

Citation No. 8342202 issued to National Coal Corporation, 30 CFR, § 77.1710(i):

As the result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, and a thorough examination of the Blue DM886SX Mack tandem axle coal truck, S/N 1M2B156CXCA002840, evidence indicated that the seat belt was not in use at the time of the accident. The right side of the seat belt found stored behind the operator's seat with the left side secured behind the lumbar handle on the rear of the seat. When tested the seat belt was firmly attached to the seat with the buckle operating properly. Seat belts shall be worn where the danger of overturning exists.

Citation No. 8342203 issued to National Coal Corporation, 30 CFR, § 77.404(a):

As a result of a fatal accident investigation at the National Coal Corporation's, Mine 5A, it has been determined that the truck operator failed to maintain control of the 1982 Blue DM-800 Mack tandem axle coal truck, Model DM886SX, S/N 1M2B156CXCA002840, while the loaded truck was descending the mine haul road. Mobile equipment operators shall have full control of the equipment while it is in motion.

APPENDIX A

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

National Coal Corporation Officials & Employees

William R. Snodgrass	Chief Operating Officer
Don McDaniel	Safety Director
Ronald Massengale	Safety Inspector
Johnny Smiddy	Supt. of Underground Mines
Ricky Cook	Assistant Mine Supt
Josh Cox	Mechanic
Richard Cox	Prep Plant Foreman
Randy Overton	Loader Operator

Cox Trucking (V865)

Isaac Nathaniel Cox	Owner
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Other Personnel

Trooper Michael Heatherly	Tennessee Highway Patrol
Keith McKamey	Contract Coal Hauler/PLM
Tony Shannon	Contract Coal Hauler/Barry Jackson Trucking

Mine Safety and Health Administration

David A. Faulkner	CMS&H Surface Inspector/ Accident Investigator
Edward F. Taylor	CMS&H Inspector/ Accident Investigator
Kevin D. Bruner	Supervisory CMS&H/ Accident Investigator
Ronald W. Burns	Supervisory CMS&H/ Accident Investigator
Clayton E. Sparks	Supervisory CMS&H/ Accident Investigator
Deborah B. Combs	Educational Field Services
Eugene D. Hennen	Mechanical Engineer, Mechanical Safety Division MSHA Approval and Certification Center
Paul J. Donahue	Civil Engineer, Pittsburgh Technical Support Mine Waste and Geotechnical Engineer Division
Ronnie L. Brock	District 7 Accident Investigation Coordinator
Jim W. Langley	Assistant District Manager
Irvin T. Hooker	District Manager

APPENDIX B

List of Persons Interviewed

Randy Overton	Loader Operator/Employee of National Coal Corp.
Keith McKamey	Contract Coal Hauler/PLM
Tony Shannon	Contract Coal Hauler/Barry Jackson Trucking
Richard Cox	Prep Plant Foreman/Employee of National Coal Corp.
Isaac Nathaniel Cox	Owner of Cox Trucking
Ricky Cook	Assistant Mine Supt. /Employee of National Coal Corp.

APPENDIX C
MSHA Form 7000-50b

Accident Investigation Data - Victim Information

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



Event Number: **4 2 4 1 1 8 0**

Victim Information: 1

1. Name of Injured/Ill Employee: <i>Darrell Seiber</i>		2. Sex: <i>M</i>	3. Victim's Age: <i>48</i>	4. Degree of Injury: <i>01 Fatal</i>											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 10/09/2009 b. Time: 8:42</i>				6. Date and Time Started: <i>a. Date: 10/09/2009 b. Time: 6:00</i>											
7. Regular Job Title: <i>076 Truck Driver</i>			8. Work Activity when Injured: <i>055 Operate haulage truck</i>			9. Was this work activity part of regular job? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
10. Experience a. This	Years	Weeks	Days	b. Regular Job Title:	Years	Weeks	Days	c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years	Weeks	Days
Work Activity:	<i>30</i>	<i>0</i>	<i>0</i>	<i>30</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>3</i>	<i>1</i>	<i>0</i>	<i>3</i>	<i>1</i>		
11. What Directly Inflicted Injury or Illness? <i>002 Bodily motion</i>				12. Nature of Injury or Illness: <i>180 Cut/laceration/puncture/opn wound/infect</i>											
13. Training Deficiencies: Hazard: <input checked="" type="checkbox"/> New/Newly-Employed Experienced Miner: <input checked="" type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>															
14. Company of Employment: (If different from production operator) <i>Cox Trucking</i>				17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>											
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input checked="" type="checkbox"/> CPR: <input checked="" type="checkbox"/> EMT: <input checked="" 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 a. This	Years	Weeks	Days	b. Regular Job Title:	Years	Weeks	Days	c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years	Weeks	Days
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)				17. Union Affiliation of Victim:											
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 a. This	Years	Weeks	Days	b. Regular Job Title:	Years	Weeks	Days	c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years	Weeks	Days
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)				17. Union Affiliation of Victim:											
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:											

