CAI-2013-04

UNITED STATES DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH
REPORT OF INVESTIGATION

Underground Coal Mine
Fatal Machinery Accident
February 13, 2013

Prairie Eagle South Underground Mine
Knight Hawk Coal LLC
Cutler, Perry County, Illinois
I.D. No. 11-03205

Accident Investigators

Harry Wilcox
Coal Mine Safety and Health Inspector

Terry Hudson
Electrical Specialist

Larry Morris
Coal Mine Safety and Health Inspector

Steven M. Miller
Supervisory Coal Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
District 8
2300 Willow Street
Vincennes, Indiana
Robert A. Simms, District Manager

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Photograph of Accident Scene Showing Continuous Mining Machine and Coal Rib

OVERVIEW

On Wednesday, February 13, 2013, Timothy Chamness (victim), a 28-year-old continuous mining machine operator, was fatally injured when he was pinned between the tail of the remote controlled continuous mining machine and the coal rib on MMU 001-0, located on the 3rd North section of the Main West entries. While repositioning the continuous mining machine to mine the final cut on the left side of the entry, the victim was pinned between the conveyor boom of the machine and the coal rib on the right side of the entry (See Appendix B).

The accident occurred because the mine operator did not ensure that the mine's roof control plan and the company policies in place at the time of the accident were being followed. The mine operator did not have engineering controls in place to prevent this type of accident. In addition, the mine operator did not have a method to prevent damage to the valve bank and solenoids component assembly on the continuous mining machine.

GENERAL INFORMATION

The Prairie Eagle South Underground Mine, I.D. No. 11-03205, is located near Cutler, Perry County, Illinois. The mine operator is Knight Hawk Coal, LLC.

The mine is accessed by five highwall drift openings into the Herrin No. 6 coal seam, which averages 7 feet in height. The mine is ventilated with one main fan which is located at the drift opening. Miners and materials are transported into the mine through the drift openings using diesel-powered equipment. Coal was being extracted by one retreating Mechanized Mining Unit (MMU 001-0) using two Joy 14CM15 continuous mining machines at the time of the accident. Coal is transported from the working faces by battery coal haulers to belt conveyors for transport to the surface. The mine employs 51 persons, with 2 production shifts, and a maintenance shift, working 5 days a week at the time of the accident. The mine was placed in active status on May 11, 2009, and production averages 6600 tons of coal per day.

A regular (E01) safety and health inspection by the Mine Safety and Health Administration (MSHA) was ongoing at the time of the accident. The previous regular safety and health inspection of the mine was completed December 20, 2012. The Non-Fatal Days Lost (NFDL) injury incidence rate for the Prairie Eagle South Underground Mine in 2012 was 5.05, compared to a National NFDL rate of 3.52.

The principal officers at this mine at the time of the accident were:
Thomas Hasenstab.....Mine Engineer
Dale Winter.....Superintendent
John Sweet .....Director, Health and Safety

DESCRIPTION OF ACCIDENT

Timothy Chamness, started work at the normal time of 3:00 p.m. for the evening shift of February 13, 2013, along with the production crew. Chamness and the production crew travelled into MMU 001-0, on the 3rd North section of the Main West entries.

The shift proceeded routinely with Chamness operating the remote controlled Joy continuous mining machine on the left side entries of MMU 001-0. Chamness began mining in the face area of the No. 1 entry, inby the last open crosscut, which was located at survey station (spad) +300 N. He had finished mining the 3rd lift of the 4-lift cut procedure for the extended 40 feet cut. The continuous mining machine was on the right side of the entry with the conveyor tail pointed toward the left side of the entry when the fully loaded battery coal hauler, operated by Curtis Williams, pulled away from the continuous mining machine and traveled to the section feeder to discharge a load of coal. Approximately one minute later, another battery coal hauler, operated by Kevin Miller, started to back into the face area of the No. 1 entry, but stopped short in the last open crosscut after Miller noticed that he could not see Chamness. At approximately 8:30 p.m., Miller walked from the last open crosscut to the continuous mining machine. Miller observed Chamness pinned to the right rib of the No. 1 entry by the tail of the continuous mining machine. Chamness was located at the second row of roof bolts outby the unsupported mine roof, facing the right rib with the tail of the continuous mining machine resting against the middle of his back. Miller noticed that the continuous mining machine's lights were energized and the hydraulic pump motor was de-energized.

Miller immediately ran from the face area of the No. 1 entry to get help. Brandon Ortega, Roof Bolter Operator, had just finished roof bolting an area in the No. 2 face and was waiting in the last open crosscut of the No.2 entry when he heard the call for help. Ortega ran to the continuous mining machine and observed Chamness pinned against the right rib. The machine's remote control unit was pinned between the coal rib and Chamness's torso. Chamness's hands were positioned on each side of the remote control unit in a normal position for operating the remote control unit. Ortega attempted to retrieve the remote control unit, but he was unsuccessful. Ryan Pedigo, Section Repairman; William Kendrick, Continuous Mining Machine Operator for the intake side; and Randy Lewis, Battery Coal Hauler Operator / EMT arrived to assist in the rescue. Pedigo crawled under the conveyor boom of the continuous mining

machine, attempting to access the remote control unit in order to swing the machine's tail off Chamness. Initially, the remote control unit would not power up. Pedigo and Lewis removed the remote control unit from Chamness by cutting the neck/shoulder strap. Pedigo was able to power up the remote control unit using another cap lamp battery. During this same time, Lewis performed an initial assessment on Chamness, who was unresponsive with no pulse detected. Pedigo passed the powered-up remote to Kendrick to operate the continuous mining machine. Kendrick attempted to swing the machine's conveyor boom off Chamness. The continuous mining machine initially did not respond to the signals from the remote control unit. Pedigo heard "clicking" sounds that he attributed to the solenoids on the valve bank of the continuous mining machine. Kendrick started the cutting head and moved one of the cat tracks on the continuous mining machine, which caused the machine to move forward approximately one foot and the conveyor boom to shift to the left a short distance, freeing Chamness. Coworkers placed Chamness on a back board and transported to the surface of the mine.

Chamness was pronounced dead by the Perry County Coroner. An autopsy was performed at the request of the Perry County Coroner's office. The cause of death was listed as blunt force trauma, resulting from a crushing injury to the chest.

INVESTIGATION OF THE ACCIDENT

Dale Winter, Mine Superintendent, was contacted at home and informed of the accident. Winter notified MSHA of the accident by calling the MSHA notification hotline at 8:56 p.m. Central Time (9:56 p.m. Eastern) on February 13, 2013. The accident occurred at 8:30 p.m. Central Time. The MSHA hotline was called 26 minutes after the mine knew of the accident. The nature of the injuries should have caused mine management to know the accident was required to be immediately reported to MSHA in accordance with 30 CFR, § 50.10(a). A citation which did not contribute to the cause of the accident was issued for failing to report this accident at once, without delay, and within 15 minutes.

Winter notified Steven Miller, Supervisory Coal Mine Inspector, of the accident. Miller issued a verbal Section 103(j) order to the mine at 9:10 p.m. An MSHA investigation was initiated by Harry E. Wilcox, Coal Mine Safety and Health Inspector, and Larry Morris, Coal Mine Safety and Health Inspector, on the evening of the accident. Terry Hudson, Electrical Specialist, assisted with the accident investigation. Jeffrey McClelland, Jay Prebeg, and Ronald Medina from MSHA Technical Support and David Brown from MSHA Educational Field Services also assisted with portions of the accident investigation.

The accident investigation was conducted in cooperation with the Illinois Department of Natural Resources, Office of Mines and Minerals (IDNR), and Knight Hawk Coal LLC. Preliminary interviews were conducted the night of the accident and formal interviews were conducted on February 14, 2013 at the mine office and on February 15, 2013 at the IDNR office in Benton, Illinois. A list of the employees interviewed is provided in Appendix C

An inspection of the accident scene and operational checks on the Joy 14CM15 continuous mining machine was conducted. Photographs, measurements, mapping, and testimony were obtained during the investigation. Additional tests were conducted and information collected from the continuous mining machine's electronic control system memory, the hydraulic valve bank, and operation solenoids with help of Joy Manufacturing in Franklin, Pennsylvania. An accident scenario reenactment was conducted by MSHA District 8 personnel and MSHA Technical Support personnel at the Magnum Steel facility in Mt. Vernon, Illinois, with the assistance of Knight Hawk Coal LLC personnel (See Appendix A).

DISCUSSION

Accident Scene

The accident occurred in the face area of the No.1 entry approximately 50 feet inby the last open crosscut on the left side of the 3rd North entries off the Main West, No. 1 Unit (MMU 001-0). The last open crosscut was located at Survey Station (Spad) +300 N for the 3rd North entries off the Main west. The right side of the entry had been advanced 38 feet beyond the last row of permanent support. The left side of the entry had been advanced 19 feet beyond the last row of permanent support. The mine had approval for cut depths up to 40 feet. The coal seam height at the last open crosscut measured 88 inches and the entry measured 20 feet in width. Coal was being mined from the right side of the entry prior to the accident. Chamness was found in the No. 1 entry, against the right rib at the second row of permanent roof support. The cutting head of the continuous mining machine was approximately ten feet from the face on the right side of the entry. Chamness was faced against the coal rib and the outby end of the continuous mining machine conveyor boom was against the middle of his back. The pump motor on the continuous mining machine was not running. This indicates that the remote control emergency stop (e-stop) or the pump "off" switch had been activated, or there was a loss of battery power to the remote control unit station. Illumination in the area was not a factor. When the continuous mining machine was energized for the investigation team, all of the lights were operative.

Equipment

The continuous mining machine involved in the accident was manufactured by Joy Mining Machinery, Remotely-Controlled Model 14CM15-11EX, Serial No. JM6284A, MSHA Approval No. 2G-4159A-0.

The remote control unit being used at the time of the accident was manufactured by Matrix Permissible Radio Transmitter (Frequency 900MHz), Model TX3, Part No. 100510082, Serial No. 172211AN026A, MSHA Approval No. 2G-4096-0.

Information from the Joy Mining Machinery identification tag indicated that the continuous mining machine was rebuilt one time since the original build. The nominal input voltage to the machine was 995 volt, 3-phase, 60 hertz. The machine was originally shipped new as serial number JM6284.

Continuous Mining Machine Examination and Testing at the Mine Site

On February 15, 2013, functional testing of the remote control system and the continuous mining machine at the post-accident location demonstrated that the machine and remote control system functioned properly. During this examination the following conditions were observed: the trailing cable was hanging down and resting on the top left side of the 'conveyor swing right' solenoid; the continuous mining machine trailing cable restraint clamp was secured by a metal chain above the continuous mining machine valve bank; and the mining machine's trailing cable and water line exited the machine on the right side and extended through a cable guide.

Abrasive wear and scuff marks were also observed on the continuous mining machine trailing cable and the restraint clamp that appeared to be from the 'conveyor swing right' solenoid's top nut. The trailing cable was moved to get a better view of the solenoids and solenoid wires. Its weight was such that a pry bar had to be used to lift it off the solenoid. The stab cylinder up and conveyor swing right solenoid wires were damaged with exposed conductors from the white-colored wires. Five control cables for the 24-volt control solenoids were found with damaged insulation. Two of the control cables had exposed bare copper conductors. The normal tramming motion of the continuous mining machine allowed the trailing cable and strain relief clamp to move and make contact with the valve bank and the solenoids. Damage to the wires of the conveyor swing right solenoid and stab cylinder up solenoid is attributed to the contact, force, and movement of the trailing cable and strain relief clamp.

MSHA Testing

MSHA's Technical Support branch participated with testing of equipment involved in the accident. They obtained the following from the mine operator: a solenoid valve bank conveyor right swing and stab jack solenoids; a JNA/Citect USB Drives, including the Tram Drive USB Drive; the continuous mining machine operator's Wheat LI cap lamp battery; and the remote control transmitter and power cord, Matric Model TX3. Tests were conducted with these components to determine if they were operating within the factory specified parameters. Data logged from the USB drives the night of the accident was also retrieved.

Additional testing was conducted to determine if the continuous mining machine trailing cable or restraint would affect the operation of the conveyor swing right function. A test protocol was developed to simulate the effect of side force being applied on the conveyor swing right solenoid from the trailing cable and the trailing cable restraint. The test protocol was utilized to conduct the test on the continuous mining machine involved in the accident. The test protocol included applying a force to the conveyor swing right solenoid in a direction perpendicular to its stem. This side load was applied in 50 pounds per square inch (psi) increments.

Side force applied to the top nut of the original tail swing solenoid caused malfunctions. At a pressure of 550 psi, which corresponds to 970 pounds of force, the conveyor swing right malfunctioned, and the conveyor continued to swing immediately after the corresponding conveyor swing button on the remote control transmitter was released. The remote control emergency stop (e-stop) was pressed to stop the conveyor from swinging. The action de-energized the continuous mining machine. The machine was re-energized and the conveyor was swung in the left direction with no observed problems, although at this same side force the conveyor swing left function would operate until the conveyor swing right function was operated.

At a pressure of 600 psi, which corresponds to 1060 pounds of force, the conveyor swing right malfunctioned and the conveyor continued to swing right after the corresponding conveyor swing button on the remote control transmitter was released. The conveyor swing left button on the remote control transmitter was not able to cause the conveyor to swing back to the left, however the electrical load on the pump motor decreased. The act of de-energizing and re-energizing the continuous mining machine failed to clear the malfunction. The tail swing functions would operate correctly when the 970 and1060 pounds of side force were removed from the conveyor swing right solenoid.

A similar test was conducted using a new valve stem for the conveyor swing right. After the 400 psi test, the solenoid body was removed and the valve stem was

inspected. The valve stem was bent. The conveyor did not swing right when the corresponding button was operated on the remote control transmitter.

The original equipment functioned according to factory specifications, without side loading. The right tail swing malfunctioned when side forces were applied to the conveyor swing right solenoid.

The event log and amperage data retrieved from the continuous mining machine at the time of the accident was compared with the data during the testing. Analysis of this data revealed near identical amperages during the malfunctions caused by the side load testing and the amperages during the operation of the conveyor swing at the time of the accident and when the victim was freed from the location that he had been pinned by the tail of the continuous mining machine. The testing also showed that when the conveyor swing right solenoid was stuck and the left swing coil was energized, the pump motor current changed from approximately 18 amperes to 8 amperes and the conveyor would not swing to the left. The conveyor swing valve spool centering in the valve bank allowed the hydraulic oil to free flow back to the hydraulic tank, instead of dumping over the tail (conveyor boom) swing relief valve. This condition is reflected in the 8 ampere value.

Roof Control Plan

Safety precautions for remote control operation of continuous mining machines were included in the approved roof control plan in effect at the time of the accident. The following statement was included in the plan: "No one shall be in the red-zone when continuous miners are being trammed from place to place or being re-positioned in the working place."

"Red Zone"

Shortly after the accident, ten preliminary interviews were conducted with employees of the mine. Follow up formal interviews with seven persons were conducted on February 13 and 14, 2013 at the mine office and on February 15, 2013 at the Office of Mines and Minerals (IDNR) in Benton, Illinois. All of the interviewed employees were questioned specifically about the "Red Zone" restrictions. The miners stated that they had been trained by the mine operator and knew about the "Red Zone." However, the accident investigation revealed that it was an ongoing practice at the mine for miners to be within the "Red Zone." The accident investigators found that coworkers had previously seen Chamness and other miners working in the "Red Zone" at the Prairie Eagle South Mine. In addition, at least one member of mine management, Richard Pasquino, Section Foreman, had been aware of previous occasions when Chamness and other miners had been within the "Red Zone." "Red Zone" violations were observed mainly by other miners during the repositioning of the continuous mining machine at

the face area between mining cut lifts when the continuous mining machine operator was working alone at the face. The investigation also revealed that the continuous mining machine operators were permitted to work alone at the face areas, except when the battery coal hauler is being loaded by the continuous mining machine.

Training and Experience

Chamness had 4 years and 2 months of mining experience, with 6 months of experience as a continuous mining machine operator. Chamness began working at the Prairie Eagle South Mine in December of 2010.

Chamness received Annual Refresher Training on February 09, 2013. The Annual Refresher Training was given by MSHA Certified Instructor, Kevin Weber. Records showed that Chamness received task training on the Joy 14CM15 Continuous Mining Machine from John Brower, Underground Mine Manager, on January 27, 2010. Chamness received task training on another Joy 14CM15 Continuous Mining Machine from David Welch, Underground Mine Manager, on October 27, 2010.

ROOT CAUSE ANALYSIS

An analysis was conducted to identify the underlying cause of the accident that was correctable through reasonable management controls. Below are the root causes identified during the analysis and the corresponding corrective action implemented to prevent a recurrence of the accident:

Root Cause: The mine operator failed to implement safety precautions contained in the approved roof control plan. The safety precautions were designed to ensure that miners do not enter dangerous areas that present pinch hazards, such as the "Red Zones," established around the remote controlled continuous mining machine. The continuous mining machine operator was located in the “Red Zone” between the continuous mining machine and the coal rib while the machine was being trammed away from the face.

1. *Corrective Action*. The mine operator was required to submit revisions to the roof control plan to the District Manager and upon approval, will implement those revisions. The revisions require: 1) All employees will be re-instructed on the “Red Zone” procedures and documented as Hazard Training on a MSHA 5000-23 Form; 2) The continuous mining machine operator will de-energize the pump motor on the continuous mining machine before anyone enters the Red Zone; 3) No one shall be in the “Red Zone” when the continuous mining machine is being trammed from place to

place or being re-positioned in the working place; 4) The mine operator will install proximity devices on continuous mining machine, Serial No. JM6284A. The remaining fleet of Knight Hawk Coal, LLC continuous mining machines will have proximity detection installed on a schedule starting in 2013, continuing through 2014 and in 2015 during full rebuilds for the continuous mining machines. Any new continuous mining machine purchased by Knight Hawk Coal, LLC will be equipped with a Proximity detection system; 5) An additional miner, "Spotter" will be assigned to assist each continuous mining machine operator in the moving of the continuous mining machine from place to place and for positioning purposes between Cut 1, 2, 3, and /or 4 as depicted in the roof control plan; 6) "Enhanced" training will be conducted for all new, inexperienced continuous mining machine operators in accordance with the approved task training program under 30 CFR § 48.7. The "Enhanced "training will consist of a minimum of 6-month equivalent program that will be documented through the use of MSHA Form 5000-23; 7) Training sessions on continuous mining machine movement will be conducted 1 week after initial training, 1 month after initial training, and quarterly in safety meetings.

Root Cause: The mine operator failed to maintain in safe operating condition the Joy Mining Machinery, Remotely-Controlled Model 14CM15-11EX, Serial No. JM6284A, MSHA Approval No. 2G-4159A-0, Continuous Mining Machine. Malfunction of the valve bank caused the tail to continue swinging to the right after the activation switch was released on the operator hand held remote control unit.

1. *Corrective Action:* The mine operator reconfigured the trailing cable anchor point to prevent the cable and restraining clamp from contacting the valve bank and solenoids components mounted on the continuous mining machine that was involved in the accident. The mine operator also worked with Joy Manufacturing to install a guard for the valve bank. The mine operator will make the same corrections to all of the continuous mining machines currently in their inventory.

CONCLUSION

The victim was killed while re-positioning the continuous mining machine and he became pinned between the machine's tail and the coal rib. The mine operator did not ensure that the mine's roof control plan and company policies in place at the time of the accident were being followed. The mine operator did not have engineering controls in place to prevent this type of accident. In addition, the mine operator did not have a method to prevent damage to the valve bank and solenoids component on the continuous mining machine.

Approved By:

Robert A. Simms

Robert A. Simms

District Manager

10/28/13

Date

ENFORCEMENT ACTIONS

1. A 103(j) Order, No. 8439087, was issued to ensure the safety of the miners until the investigation could be completed.

2. A 104(d) (1) Citation, No. 8439096, was issued citing 30 CFR § 75.220(a)(1). A fatal accident occurred on 2/13/2013 at approximately 8:30 P.M. in the face of No. 1 entry (50 feet inby spad 300 North) of the 3rd North Section (MMU 001-0) off the Main West entries. The operator of the remote controlled continuous mining machine was pinned between the conveyor tail of Joy continuous mining machine (Model 14CM15-11EX, Serial Number JM6284A) and the right rib of the entry while re-positioning the continuous mining machine from the completed third cut to the fourth cut at the No. 1 face. The mine operator failed to comply with the requirements listed on page 6 of the approved mine roof control plan, "Safety Precautions for Remote Control Mining: No one shall be in the red-zone when continuous miners are being trammed from place to place or being re-positioned in the working place." The mine operator failed to ensure that employees did not work or travel in the red-zone around the remote controlled continuous miner. The mine operator engaged in aggravated conduct constituting more than ordinary negligence in that the mine operator had observed the victim in the red zone before the date of the fatal accident and failed take action to prevent this hazard from re-occurring. This is an unwarrantable failure to comply with a mandatory standard. Standard 75.220(a) (1) was cited 2 times in two years at mine 1103205 (2 to the operator, 0 to a contractor). This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(a) Citation, No. 8448666, was issued citing 30 CFR § 75.512. The Joy 14CM-15, serial number JM6284A, was not being maintained to assure safe operating conditions. The machine's trailing cable restraining clamp was located in such a manner that it was

interfering and damaging the machine's hydraulic valve bank assembly. When inspected five of the solenoid coil control cables have been damaged, with bare copper conductors showing on two of the coil control cables. The damaged control cables were the tail swing right, and the stab up functions. This indicates that a complete and thorough examination was not done, as required by this section. In addition, data from the machine's onboard computer system along with information gained during the interview process indicate that the tail swing right function was continuously being initiated by the hydraulic system of the continuous mining machine thus contributing toward the cause of the fatal accident that occurred on 02/13/2013.

Appendix A

Persons Participating in the Investigation

Mine Safety and Health Administration

Harry Wilcox	CMS&H Inspector, Accident Investigator
Terry Hudson	CMS&H Inspector, Electrical Specialist
Larry Morris	CMS&H Inspector, Accident Investigator
David Brown	Training Specialist (EFS)
Jeffrey K McClelland	Electrical Engineer, Technical Support
Frank Jay Prebeg	Electrical Engineer, Technical Support
Ronald Medina	Mechanical Engineer, Technical Support

Knight Hawk Coal, LLC, Prairie Eagle South Mine

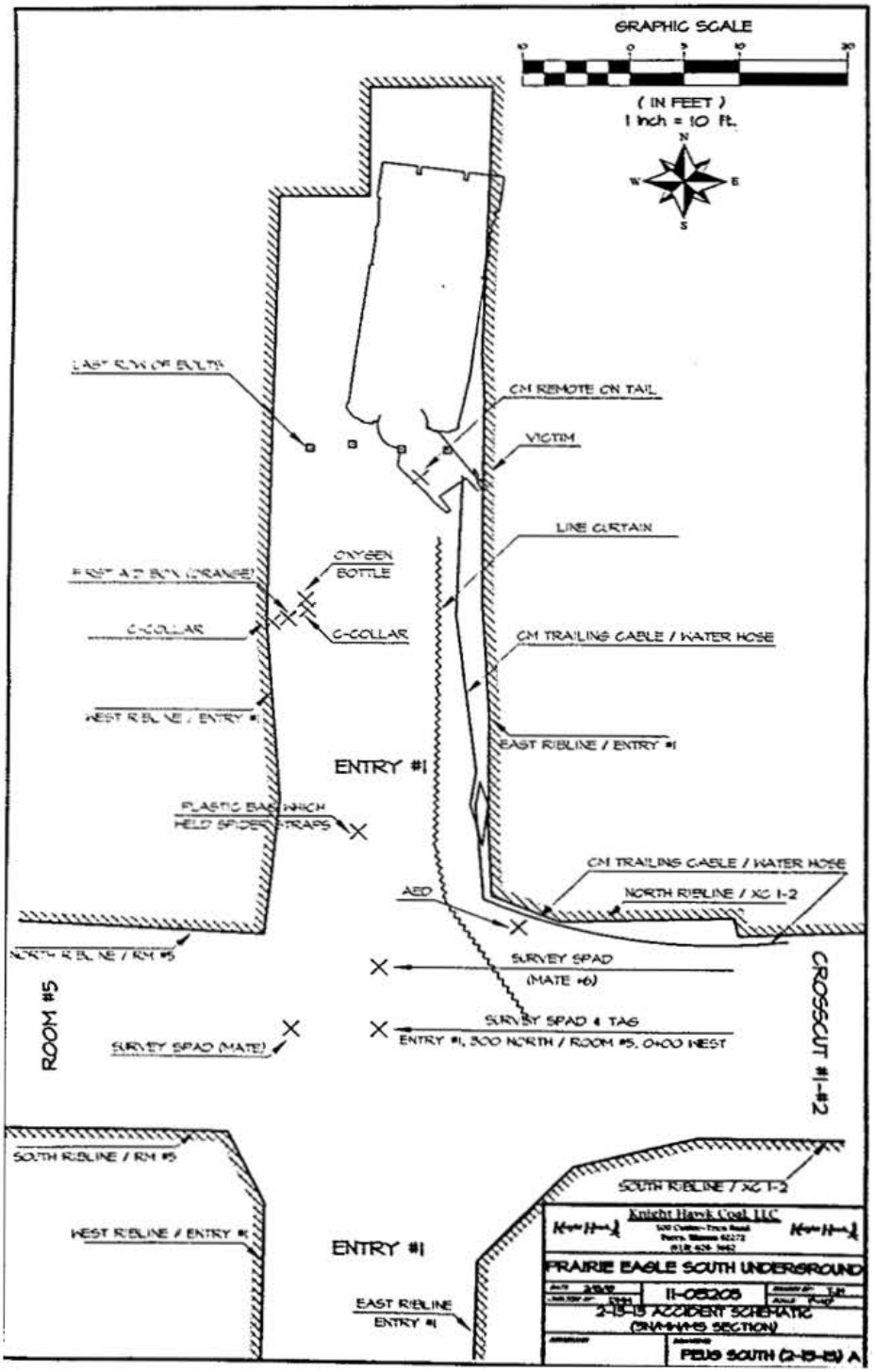
Thomas Hasenstab	Mine Engineer
Dale Winter	Superintendent
William Jankousky	Corporate Director, Health and Safety
John Sweet	Mine Safety Director
Michael Followell	Manager of Maintenance

State of Illinois Department of Natural Resources, Office of Mines and Minerals

Doug Eggers	Inspector
Larry Jenkel	Electrical Inspector
John Gabby	Inspector
Gary Roberts	Inspector

Appendix B

Accident Scene



Appendix C

List of Knight Hawk Coal, LLC, Employees Interviewed

Jarad Carlton	Curtain/Utility Person
Paul Edwards	Roof Bolter Operator
William Kendrick	Continuous Miner Operator
Randy R. Lewis	Battery Coal Hauler Operator
Kevin Lee Miller	Battery Coal Hauler Operator
Brandon Thomas Ortega	Roof Bolter Operator
Richard Pasquino	Section Foreman
Ryan Pedigo	Section Repairman
Jason Stephenson	Scoop Operator
Randall Curtis Williams	Battery Coal Hauler Operator

Appendix D Victim Information

Accident Investigation Data - Victim Information
Event Number: 4 2 5 4 4 1 8

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

Victim Information: 1

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Degree of Injury:
Timothy K. Chamness	*M*	*28*	*01 Fatal*

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:	6. Date and Time Started:
a. Date: 02/13/2013 b.Time: 21:08	*a. Date: 02/13/2013 b.Time: 15:00*

7. Regular Job Title:	8. Work Activity when Injured:	9. Was this work activity part of regular job?
036 Continuous Miner Operator	*049 Operate Continuous Miner*	Yes X No

10. Experience	Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days
a. This Work Activity:	*0*	*26*	*0*	b. Regular Job Title:	*0*	*26*	*0*	c: This Mine:	*2*	*6*	*0*	d. Total Mining:	*4*	*7*	*4*

11. What Directly Inflicted Injury or Illness?	12. Nature of Injury or Illness:
077 Underground Mining Machine	*170 Crushing*

13. Training Deficiencies:
Hazard: | New/Newly-Employed Experienced Miner: | Annual: | Task:

14. Company of Employment: (If different from production operator)
Operator
Independent Contractor ID: (If applicable)

15. On-site Emergency Medical Treatment:
Not Applicable: | First-Aid: | CPR: | EMT: X | Medical Professional: | None:

16. Part 50 Document Control Number: (form 7000-1)

17. Union Affiliation of Victim: *9999* *None (No Union Affiliation)*