

Attachment 3

Coal Mine Operator's Plan – CDC/NIOSH (M) 2.10

2 page form (printed front and back)

Retrieve Data

Reset Form

Form Approved OMB No.: 0920-0020

DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH COAL MINE OPERATOR'S PLAN				FOR NIOSH USE ONLY			
RETURN TO	NIOSH COAL WORKERS' HEALTH SURVEILLANCE PROGRAM PO Box 4258 MORGANTOWN, WEST VIRGINIA 26504			Name of Company Officer in Charge of Program			
				1. _____			
Name of Mine Operator				Telephone Number			
3. _____				4. _____			
Street Address			City	State	Zip Code		
5. _____			6. _____	7. <input type="text"/>	8. _____		
Mine Name			Mine Identification Number			Number Miners	
9. _____			10. _____			11. _____	
Mine Mailing Address (Box Number, Street)			City	State	Zip Code	County	
12. _____			13. _____	14. <input type="text"/>	15. _____	16. _____	
Name(s) of X-Ray Facility(ies)				Certification Number	Number Miles from Mine		
17. _____				18. _____	19. _____		
Name(s) of Interpreting Physician(s)				Physician's Address			
20. _____				21. _____			
Time Schedule	Begin Date	End Date	Days	Hours			
6 mos+ <input type="text"/>	22. <input type="text"/>	23. <input type="text"/>	24. <input type="text"/>	25. <input type="text"/>			
Remarks (if given at mine, include number of change houses and location and name of change houses where mobile facility will set up.)							
26. _____							
<p>I am participating in this program in the manner specified by Part 37 of the Title 42 of the Code of Federal Regulations (42 CFR Part 37) and understand that all information used in connection with this program will be held STRICTLY CONFIDENTIAL and divulged only as specified by the above regulations. I hereby assure that (1) the X-Ray findings or findings of any medical test of any miner examined under this plan will not be solicited from the Physician or Facility providing the examination; (2) I have advised the Physician and Facility providing the examinations under this plan that duplicate X-Rays or test results are not to be taken or made and no information that would identify the miner shall be recorded on the film or test results except as provided in the above Regulation; and (3) all examination made under this plan will be at no cost to the miner.</p>							
Date				Signature of Mine Operator or Legal Representative			
27. _____							

CDC/NIOSH (M) 2.10 Rev. 07/2007 **SEE REVERSE SIDE FOR INSTRUCTIONS**

Public reporting burden of this collection of information is estimate to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA, 30333 ATTN:PRA (0920-0020). Do not send the completed form to this address.

Save Data

Print

Email Form

Next Page

**Instructions for Completion of
Coal Mine Operator Plan
Form N. CDC/NIOSH(M)2.10**

- 1 _____ Name of Company Officer In Charge of Program - Name of Individual to be contacted relative to implementation of plan.
- 2 _____ Title - Title of individual listed in block #1.
- 3 _____ Name of Mine Operator - Name of Mine Operator or parent company.
- 4 _____ Telephone Number - Telephone number for contact purposes for information relative to coal mine operator plan (individual noted in block # 1)
- 5 thru 8 _____ Address of mine operator or parent company
- 9 _____ Name of Mine - Specific name of mine (not company).
- 10 _____ Mine Identification Number - Identification Number assigned by MSHA
- 11 _____ Number Miners - Approximate number of miners employed or to be employed
- 12 thru 15 _____ Mine Mailing Address - Mine address, not company address (address where approved plan will be sent.)
- 16 _____ County - Name of county where mine is located
- 17 _____ Name(s) of X-ray Facility(ies) - Facility(ies) where examinations are to be conducted. If mobile facility is to be used, a local facility should also be named to conduct pre-employment and mandatory examinations.
- 19 _____ Certification Number - NIOSH Certification Number (can be located in facility list)
- 19 _____ Number Miles from Mine - Distance from facility to mine
- 20 thru 21 _____ Name and Address of Interpreting Physician - Name and address of physician(s) who will read films for the facility where films are made (this information can be obtained from the facility)

TIME SCHEDULE

- 22 _____ Begin date - Beginning date of period during which miners will have an opportunity for x-rays. If mine is new, program should begin within one month of the date you submit your plan. If mine is not yet in operation, program should begin when hiring starts to allow for pre-employment x-rays. If a mobile facility is to be used, the begin date should indicate the first date that the mobile unit will be at the mine. Enter date (month, day, year) when examinations will begin.
- 23 _____ End Date - End date of 6-month period during which miners will have opportunity for x-rays. Program should end six months after beginning date. If a mobile facility is to be used, the end date should indicate the last date that the mobile unit will be at the mine. Enter date (month, day, year) when examinations will stop (voluntary examinations only).
- 24 _____ Days - Days of week when miners may be examined (i.e., Mon-Fri)
- 25 _____ Hours - Hours during each day when miners may be examined at facility (i.e., 8-0-0 a.m. thru 4-00 p.m.). If mobile unit is to be used hours are usually one hour before and one hour after shift change.
- 26 _____ Remarks - Other pertinent information. Indicate which facility will conduct mandatory and /or repeat x-rays. If using mobile facility indicate the number of change houses, location and name of change houses where facility will be set up. Indicate if miners may be examined at facility on a walk-in basis, or if appointment will be required, whether or not miners work rotating shifts, and if appointments will be made at miners convenience or will miners be released from work.
- 27 _____ Signature (must be original, not stamp or copy) and date plan is submitted.