

Screen Shots

MSHA Form 7000-1

UNITED STATES DEPARTMENT OF LABOR

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Mine Safety and Health Administration
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Mine Accident, Injury and Illness Report (7000-1)

Step 1: Select form submission type > Step 2: Mine information > Step 3: Occurrence Information > Step 4: Accident Location > Step 5: Accident Date/Time > Step 6: Accident Equipment > Step 7: Individual Injury/Illness > Step 8: Summary

Step 1: Select type of form submission

- File initial mine accident, injury and illness report
- File Return to Duty (pink form) for an existing mine accident, injury and illness report
- Revise E-Document

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Mine Safety and Health Administration (MSHA) | 1100 Wilson Boulevard, 21st Floor Arlington, VA 22209-3939
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Step 2: Fill out Mine information

* Mine ID

Mine Name No 7 Mine

Company Name Jim Walter Resources Inc

Mine Type Underground

Coal /Metal COAL

* Are you a contractor? Yes No Contractor ID

* Has there been an accident that must be immediately reported to MSHA? Yes No

[Click here to find out what is immediately reportable](#)

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Step 4: Specify the accident location

* Select the code that best describes where the Accident/Injury/Illness occurred. If it was a surface location, please select only the location. If it was an underground location, select the location and the underground mining method.

Surface Location

-- OR --

Underground Location

Underground Mining Method

(* Required Fields)

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Step 5: Fill out the date and time information of the accident

* Date of Accident (mm/dd/yyyy)

* Time of Accident am pm Accident Time is Unknown

* Time Shift Started am pm

* Describe Fully the Conditions Contributing to the Accident/Injury/Illness, and Quantify the Damage or Impairment (limited to 384 characters)

(* Required Fields)

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Step 6: Fill out accident equipment information and witness name

If there was equipment involved indicate the type, manufacturer and model below. If equipment was not involved leave the fields blank.

Type

Manufacturer

Model Number

If there was a witness please enter the name of that person below. If there was not a witness then leave the field blank.

First Name of Witness

Last Name of Witness

(* Required Fields)

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Step 7: Enter Individual injured or ill from this occurrence

Was there any individual injured or ill as a result of this occurrence?

Yes No

(* Required Fields)

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Individual Information

First Name of Injured/ill Employee

Last Name of Injured/ill Employee

Last Four Digits of Social Security Number

Regular Job Title

Date of Birth

Sex Male Female

Did this injury/illness result in death? Yes No

Did this injury/illness result in permanent disability? Yes No

Accident Information

What directly inflicted injury or illness?

Nature of injury or illness

Part of the body affected

Occupational Illness

Employee's work activity when injury/illness occurred

Experience in this job title Years Weeks

Experience at this mine Years Weeks

Total mining experience Years Weeks

Return to Duty Information

Was this person permanently transferred or terminated as a result of this occurrence? Yes No

Has the person returned to work at full capacity? Yes No

Date returned to regular job at full capacity or was terminated/transferred

Number of workdays the person did not report to the workplace between date of occurrence and date the person returned to work or was terminated/transferred

Number of workdays the person was restricted on work activity between date of occurrence and date the person returned to work or was terminated/transferred

If the person has not returned to work or information on the termination or transfer is not available with the submission today it must be updated when the information is available. You can do this by selecting the Return To Duty option at the beginning of this form when you are ready.

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Accident/Equipment > **Step 7: Individual Injury/Illness** > Step 8: Summary

Step 7: Enter Individual injured or ill from this occurrence

| SSN | Full Name | | |
|------|-----------|------------------------|----------------------|
| 1916 | XX | Delete | Edit |

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Mine information [Edit](#)

Mine ID 01-01401
Mine Name No 7 Mine
Mine Type Underground/ Coal
Company Name Jim Walker Resources Inc.

Occurrence information [Edit](#)

Injury/Illness Location Surface - (30) Hill, Prep Plant, etc.

Accident Date 1/1/2001 **Accident Time** 5:00 AM
Time Shift Started 5:00 AM

Conditions Contributing to the Accident/Injury/Illness

xxx

Number of People Affected 1

Individual Illness/Injury information [Edit](#)

Name x x **Last Four SSN** 1919
Regular Job Title x **Date of Birth** 10/22/2002
Sex Female
What inflicted Injury/Illness x **Nature of Injury/Illness** x
Part of Body Affected x **Result in Death?** No
Result in Disability? No **Occupational Illness Code**
Work Activity when Injured v **Return To Work Date** 8/8/2008
Experience at Job Title 0 Years and 1 Weeks **Days before returned to work** 0
Experience at Mine 0 Years and 1 Weeks **Days on restriction** 0
Total Experience 0 Years and 1 Weeks

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