

| | | | | | | | |
|---|---|------------------------|-----------------|---|--------------------------------------|-----------------|--|
| COAL MINE OPERATOR'S PLAN DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH | | | | 1. MSHA Mine Identification Number | | | |
| | | | | 2. Name of Company Officer in Charge of Program | | | |
| RETURN TO | NIOSH Coal Workers' Health Surveillance Program 1000 Frederick Lane, M/S LB208 Morgantown, WV 26508 Fax: 304-285-6058 | | | 3. Email Address of Company Officer | | | |
| | | | | 4. Title of Company Officer in Charge | | | |
| 5. Name of Mine Operator/Company | | | | 6. Telephone Number | | | |
| 7. Street Address | | | 8. City | | 9. State | 10. Zip Code | |
| 11. Mine Name | | | | 12. County | | 13. # of Miners | |
| 14. Mine Mailing Address (Box number, Street) | | | 15. City | | 16. State | 17. Zip Code | |
| Open period for obtaining examination (6 months plus) | | 18. Begin Date | | | 19. End Date | | |
| To be completed by NIOSH | | 20. Plan Approved Date | | | 21. Plan Expiration Date | | |
| 22. MSHA District | 23. Mine Type | | 24. Mine Status | | 25. Plan Duration (3, 4, or 5 years) | | |
| 26. Remarks | | | | | | | |
| <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 treated in a secure manner and will not be disclosed, unless otherwise compelled by law. I hereby assure that (1) the findings of any medical tests 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 radiographs 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 examinations made under this plan will be at no cost to the miner.</p> | | | | | | | |
| 27. Signature of Mine Operator or Legal Representative | | | | | Date | | |
| 28. Signature of NIOSH Approver (NIOSH ONLY) | | | | | Date | | |
| Complete the reverse side of form indicating each Facility Identification. | | | | | | | |

CDC/NIOSH (M) 2.10, Rev. 03/2021

Public reporting burden for collection of this 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-74, Atlanta, GA, 30333 ATTN: PRA (0920-0020). Do not send the completed form to this address.

| 29. Name(s) of Radiograph Facility(ies) | 30. Facility Number | 31. # Miles from Mine | 32. Days of Operation | 33. Hours of Operation |
|---|---------------------|-----------------------|-----------------------|------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |



| 34. Name(s) of Spirometry Facility(ies) | 35. Facility Number | 36. # Miles from Mine | 37. Days of Operation | 38. Hours of Operation |
|---|---------------------|-----------------------|-----------------------|------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |