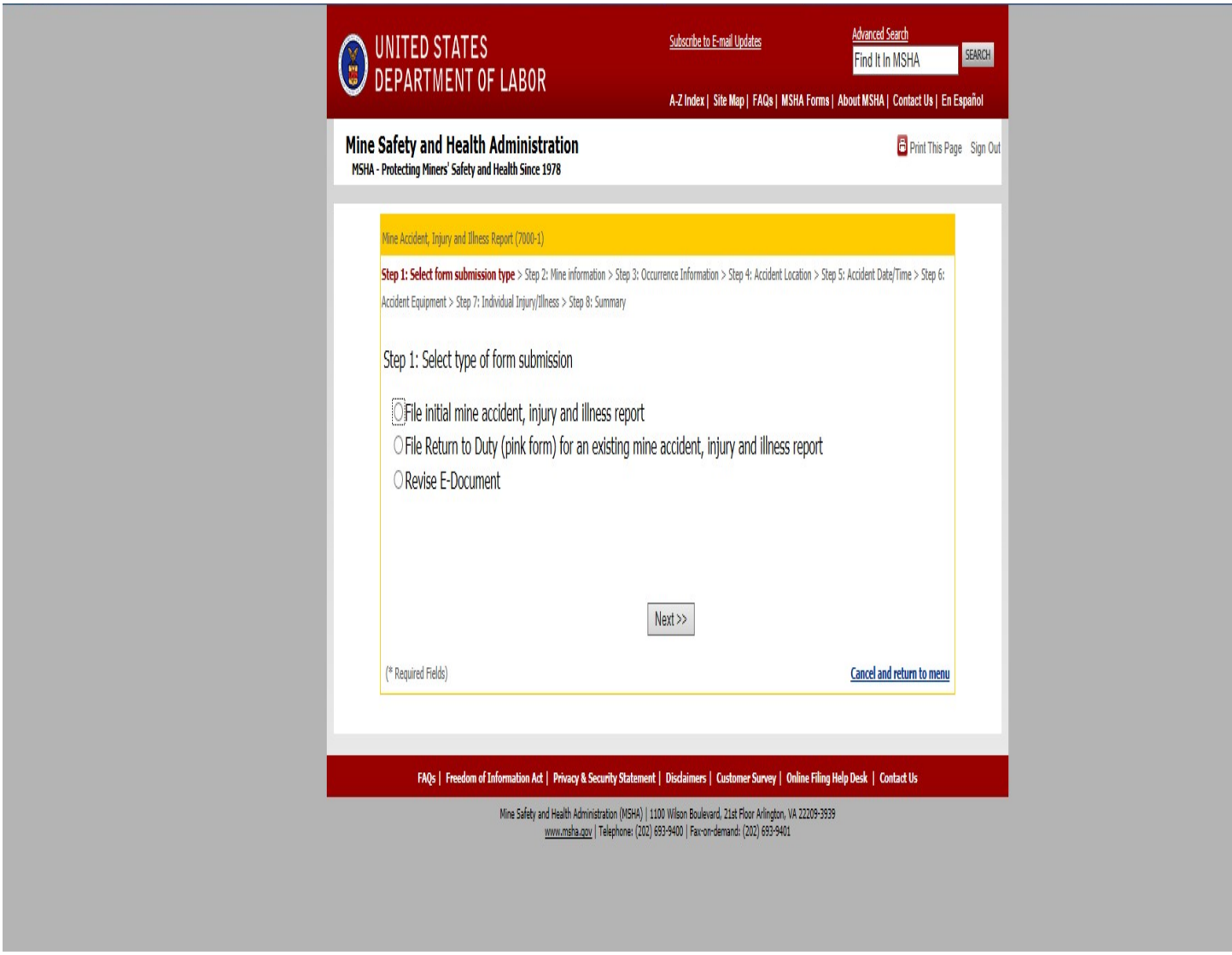
Screen Shots

MSHA Form 7000-1



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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 2: Fill out Mine information

* Mine ID 0101401 Retrieve Mine Information

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: (30) Mill, Prep Plant, etc

-- OR --

Underground Location: (02) Slope/Inclined Shaft

Underground Mining Method: (03) Conventional Stoping

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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)

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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

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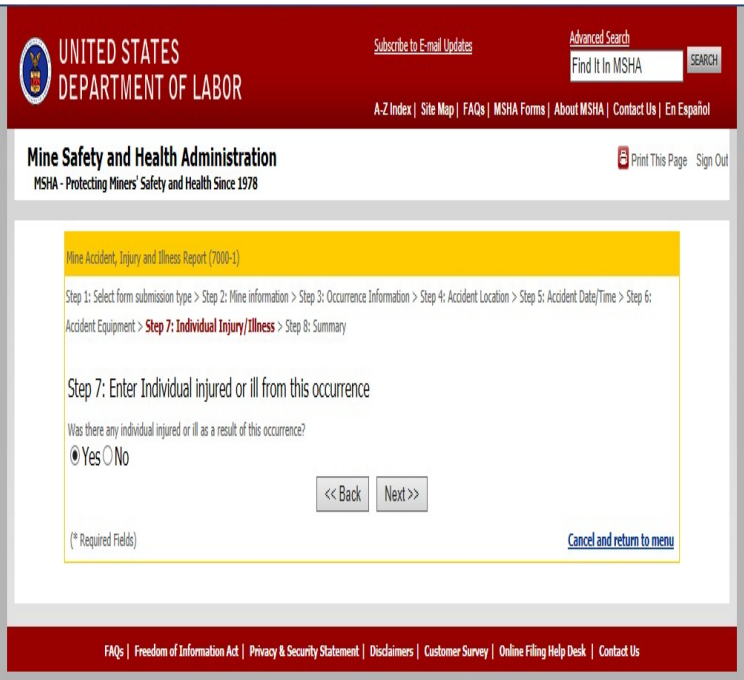
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Step 7: Enter Individual injured or ill from this occurrence
Was there any individual injured or ill as a result of this occurrence?
Yes
No
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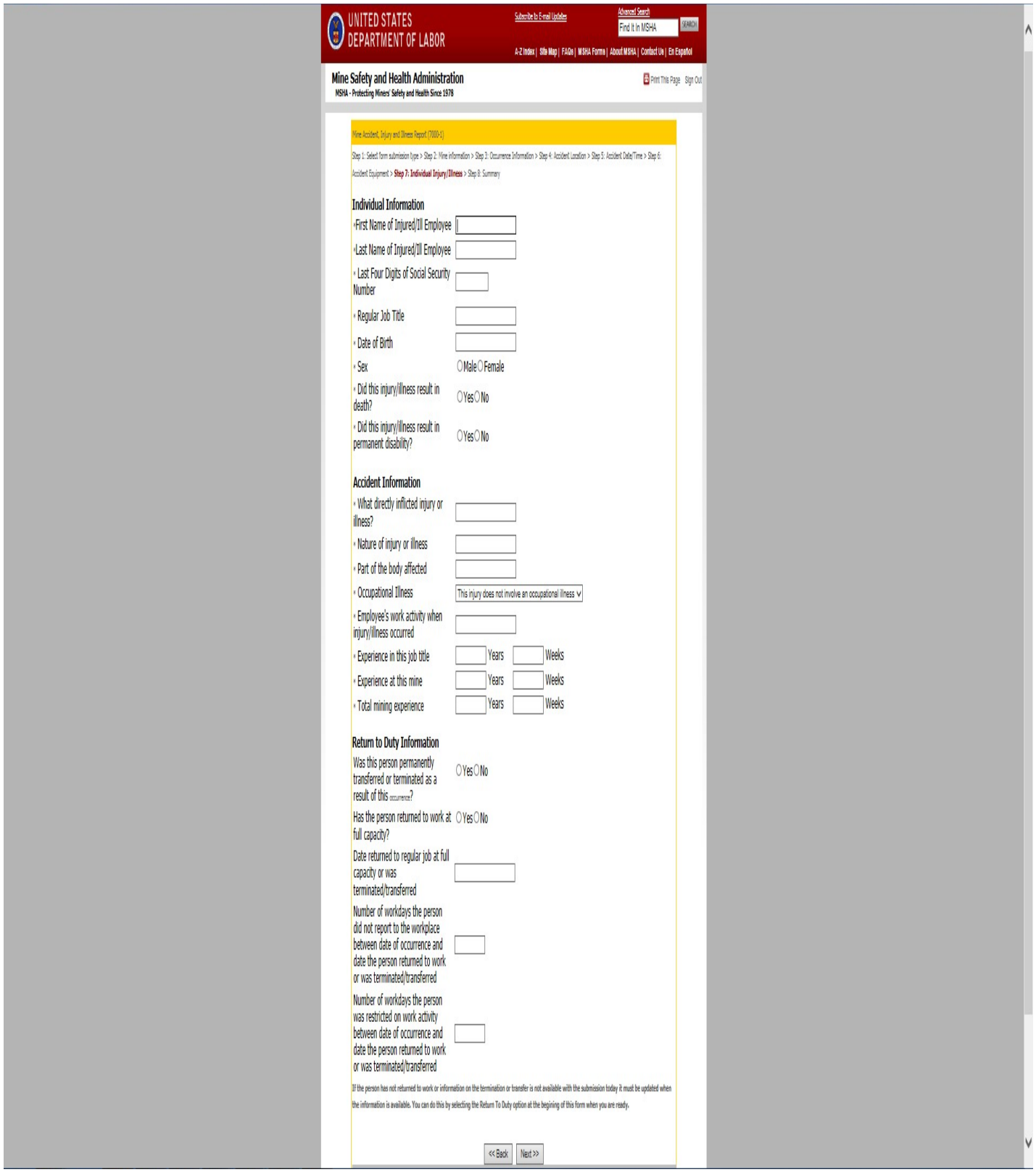

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Individual Information

- *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: This injury does not involve an 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 begining of this form when you are ready.

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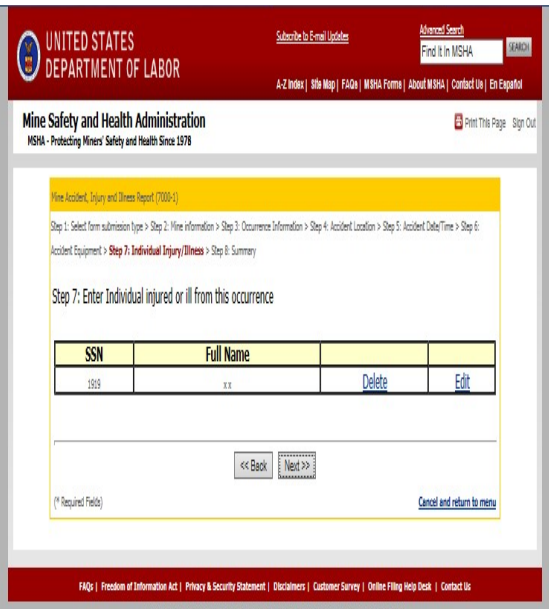
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Step 7: Enter Individual injured or ill from this occurrence
SSN
Full Name
1919
xx
Delete
Edit
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Mine information Edit

Mine ID 01-00401
Mine Name No 7 Mine
Mine Type Underground Coal
Company Name Jim Walter Resources Inc

Occurrence information Edit

Injury/Illness Location Surface - (30) Mill, 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 9 **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

Submit this form to MSHA | Click here to add another 7000-1 form

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