

## Appendix B - Victim Data Sheets

Accident Investigation Data - Victim Information												U.S. Department of Labor																			
Event Number: 4 4 7 6 4 3 5												Mine Safety and Health Administration																			
<b>Victim Information: 1</b>																															
1. Name of Injured/III Employee: <i>Kerry Allred</i>			2. Sex <i>M</i>		3. Victim's Age <i>57</i>		4. Degree of Injury: <i>01 Fatal</i>																								
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 08/06/2007 b. Time: 2:48</i>						6. Date and Time Started: <i>a. Date: 08/05/2007 b. Time: 18:00</i>																									
7. Regular Job Title: <i>050 Shuttle Car Operator</i>				8. Work Activity when Injured: <i>099 Unknown</i>				9. Was this work activity part of regular job? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
10. Experience		Years		Weeks		Days		b. Regular		Years		Weeks		Days		c. This		Years		Weeks		Days		d. Total		Years		Weeks		Days	
a. This																															
Work Activity:		<i>27</i>		<i>40</i>		<i>0</i>		Job Title:		<i>18</i>		<i>28</i>		<i>0</i>		Mine:		<i>18</i>		<i>28</i>		<i>0</i>		Mining:		<i>27</i>		<i>40</i>		<i>0</i>	
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>												12. Nature of Injury or Illness: <i>390 Unknown</i>																			
13. Training Deficiencies Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>																															
14. Company of Employment: (If different from production operator) <i>Operator</i>												Independent Contractor ID: (if applicable)																			
15. On-site Emergency Medical Treatment Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>																															
16. Part 50 Document Control Number: (form 7000-1)						17. Union Affiliation of Victim: <i>9999</i>						<i>None (No Union Affiliation)</i>																			
<b>Victim Information: 2</b>																															
1. Name of Injured/III Employee: <i>Don Erickson</i>			2. Sex <i>M</i>		3. Victim's Age <i>50</i>		4. Degree of Injury: <i>01 Fatal</i>																								
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 08/06/2007 b. Time: 2:48</i>						6. Date and Time Started: <i>a. Date: 08/05/2007 b. Time: 18:00</i>																									
7. Regular Job Title: <i>050 Shuttle Car Operator</i>				8. Work Activity when Injured: <i>099 Unknown</i>				9. Was this work activity part of regular job? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
10. Experience		Years		Weeks		Days		b. Regular		Years		Weeks		Days		c. This		Years		Weeks		Days		d. Total		Years		Weeks		Days	
a. This																															
Work Activity:		<i>0</i>		<i>32</i>		<i>0</i>		Job Title:		<i>0</i>		<i>32</i>		<i>0</i>		Mine:		<i>2</i>		<i>32</i>		<i>0</i>		Mining:		<i>15</i>		<i>40</i>		<i>0</i>	
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>												12. Nature of Injury or Illness: <i>390 Unknown</i>																			
13. Training Deficiencies Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>																															
14. Company of Employment: (If different from production operator) <i>Operator</i>												Independent Contractor ID: (if applicable)																			
15. On-site Emergency Medical Treatment Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>																															
16. Part 50 Document Control Number: (form 7000-1)						17. Union Affiliation of Victim: <i>9999</i>						<i>None (No Union Affiliation)</i>																			
<b>Victim Information: 3</b>																															
1. Name of Injured/III Employee: <i>Juan Carlos Payan</i>			2. Sex <i>M</i>		3. Victim's Age <i>22</i>		4. Degree of Injury: <i>01 Fatal</i>																								
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 08/06/2007 b. Time: 2:48</i>						6. Date and Time Started: <i>a. Date: 08/05/2007 b. Time: 18:00</i>																									
7. Regular Job Title: <i>047 Roof Bolter Operator</i>				8. Work Activity when Injured: <i>099 Unknown</i>				9. Was this work activity part of regular job? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
10. Experience		Years		Weeks		Days		b. Regular		Years		Weeks		Days		c. This		Years		Weeks		Days		d. Total		Years		Weeks		Days	
a. This																															
Work Activity:		<i>2</i>		<i>40</i>		<i>0</i>		Job Title:		<i>2</i>		<i>40</i>		<i>0</i>		Mine:		<i>2</i>		<i>40</i>		<i>0</i>		Mining:		<i>6</i>		<i>4</i>		<i>0</i>	
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>												12. Nature of Injury or Illness: <i>390 Unknown</i>																			
13. Training Deficiencies Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>																															
14. Company of Employment: (If different from production operator) <i>Operator</i>												Independent Contractor ID: (if applicable)																			
15. On-site Emergency Medical Treatment Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>																															
16. Part 50 Document Control Number: (form 7000-1)						17. Union Affiliation of Victim: <i>9999</i>						<i>None (No Union Affiliation)</i>																			

Accident Investigation Data - Victim Information

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



Event Number: 4 4 7 6 4 3 5

**Victim Information: 4**

1. Name of Injured/Ill Employee: <i>Jose Luis Hernandez</i>	2. Sex <i>M</i>	3. Victim's Age <i>23</i>	4. Degree of Injury: <i>01 Fatal</i>
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 08/06/2007 b. Time: 2:48</i>		6. Date and Time Started: <i>a. Date: 08/05/2007 b. Time: 18:00</i>	
7. Regular Job Title: <i>050 Shuttle Car Operator</i>	8. Work Activity when Injured: <i>099 Unknown</i>		9. Was this work activity part of regular job? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
10. Experience a. This Work Activity: <i>0 8 0</i>	b. Regular Job Title: <i>0 8 0</i>	c. This Mine: <i>0 8 0</i>	d. Total Mining: <i>5 8 0</i>
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>	12. Nature of Injury or Illness: <i>390 Unknown</i>		
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>			
14. Company of Employment: (If different from production operator) <i>Operator</i>		Independent Contractor ID: (if applicable)	
15. On-site Emergency Medical Treatment: Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)		17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>	

**Victim Information: 5**

1. Name of Injured/Ill Employee: <i>Brandon Phillips</i>	2. Sex <i>M</i>	3. Victim's Age <i>24</i>	4. Degree of Injury: <i>01 Fatal</i>
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 08/06/2007 b. Time: 2:48</i>		6. Date and Time Started: <i>a. Date: 08/05/2007 b. Time: 18:00</i>	
7. Regular Job Title: <i>024 Trainee</i>	8. Work Activity when Injured: <i>099 Unknown</i>		9. Was this work activity part of regular job? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
10. Experience a. This Work Activity: <i>0 3 0</i>	b. Regular Job Title: <i>0 3 0</i>	c. This Mine: <i>0 3 0</i>	d. Total Mining: <i>0 3 0</i>
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>	12. Nature of Injury or Illness: <i>390 Unknown</i>		
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>			
14. Company of Employment: (If different from production operator) <i>Operator</i>		Independent Contractor ID: (if applicable)	
15. On-site Emergency Medical Treatment: Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)		17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>	

**Victim Information: 6**

1. Name of Injured/Ill Employee: <i>Manuel Sanchez</i>	2. Sex <i>M</i>	3. Victim's Age <i>42</i>	4. Degree of Injury: <i>01 Fatal</i>
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 08/06/2007 b. Time: 2:48</i>		6. Date and Time Started: <i>a. Date: 08/05/2007 b. Time: 18:00</i>	
7. Regular Job Title: <i>036 Continuous Mining Machine Operator</i>	8. Work Activity when Injured: <i>099 Unknown</i>		9. Was this work activity part of regular job? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
10. Experience a. This Work Activity: <i>0 24 0</i>	b. Regular Job Title: <i>0 24 0</i>	c. This Mine: <i>5 35 0</i>	d. Total Mining: <i>15 2 0</i>
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>	12. Nature of Injury or Illness: <i>390 Unknown</i>		
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>			
14. Company of Employment: (If different from production operator) <i>Operator</i>		Independent Contractor ID: (if applicable)	
15. On-site Emergency Medical Treatment: Not Applicable: <input checked="" type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)		17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>	

Accident Investigation Data - Victim Information

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



Event Number: 4 0 1 1 3 6 1

**Victim Information: 1**

1. Name of Injured/Ill Employee: *Brandon Kimber* 2. Sex: *M* 3. Victim's Age: *29* 4. Degree of Injury: *01 Fatal*

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: *a. Date: 08/16/2007 b. Time: 20:25* 6. Date and Time Started: *a. Date: 08/16/2007 b. Time: 6:00*

7. Regular Job Title: *049 Foreman* 8. Work Activity when Injured: *083 Setting Props* 9. Was this work activity part of regular job? Yes  No  X

10. Experience: *a. This* Years Weeks Days *b. Regular* Years Weeks Days *c. This* Years Weeks Days *d. Total* Years Weeks Days  
 Work Activity: *0 1 2* Job Title: *2 37 0* Mine: *2 37 0* Mining: *3 0 0*

11. What Directly Inflicted Injury or Illness? *122 Side or rib* 12. Nature of Injury or Illness: *370 Blunt force trauma to chest/Asphyxia*

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:  X EMT:  X Medical Professional:  None:

16. Part 50 Document Control Number: (form 7000-1) 17. Union Affiliation of Victim: *9999 None (No Union Affiliation)*

**Victim Information: 2**

1. Name of Injured/Ill Employee: *Dale R. Black* 2. Sex: *M* 3. Victim's Age: *49* 4. Degree of Injury: *01 Fatal*

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: *a. Date: 08/16/2007 b. Time: 18:51* 6. Date and Time Started: *a. Date: 08/16/2007 b. Time: 6:00*

7. Regular Job Title: *049 Foreman* 8. Work Activity when Injured: *083 Setting Props* 9. Was this work activity part of regular job? Yes  No  X

10. Experience: *a. This* Years Weeks Days *b. Regular* Years Weeks Days *c. This* Years Weeks Days *d. Total* Years Weeks Days  
 Work Activity: *0 1 2* Job Title: *23 21 6* Mine: *23 21 6* Mining: *23 21 6*

11. What Directly Inflicted Injury or Illness? *122 Side or Rib* 12. Nature of Injury or Illness: *370 Blunt Trauma to Head/Multiple Skull Frac*

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:

**Victim Information: 3**

1. Name of Injured/Ill Employee: *Gary L. Jensen* 2. Sex: *M* 3. Victim's Age: *53* 4. Degree of Injury: *01 Fatal*

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: *a. Date: 08/16/2007 b. Time: 21:50* 6. Date and Time Started: *a. Date: 08/16/2007 b. Time: 14:00*

7. Regular Job Title: *095 MSHA Inspector* 8. Work Activity when Injured: *083 Setting Props* 9. Was this work activity part of regular job? Yes  No  X

10. Experience: *a. This* Years Weeks Days *b. Regular* Years Weeks Days *c. This* Years Weeks Days *d. Total* Years Weeks Days  
 Work Activity: *0 1 2* Job Title: *35 0 0* Mine: *0 0 0* Mining: *35 0 0*

11. What Directly Inflicted Injury or Illness? *122 Side or Rib* 12. Nature of Injury or Illness: *370 Blunt Force Injury*

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

14. Company of Employment: (If different from production operator) *Mine Safety and Health Administration* 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:

Accident Investigation Data - Victim Information

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



Event Number: 4 0 1 1 3 6 1

**Victim Information: 7**

1. Name of Injured/III Employee: <i>Carl J. Gressmen</i>	2. Sex <i>M</i>	3. Victim's Age <i>37</i>	4. Degree of Injury: <i>03 Days away from work only</i>
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:		6. Date and Time Started: <i>a. Date: 08/16/2007 b. Time: 6:00</i>	
7. Regular Job Title: <i>001 Beltman</i>	8. Work Activity when Injured: <i>083 Setting Props</i>		9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>X</b>
10. Experience a. This Work Activity: <i>0 1 2</i>	b. Regular Job Title: <i>0 1 4</i>	c. This Mine: <i>0 1 4</i>	d. Total Mining: <i>3 0 0</i>
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>		12. Nature of Injury or Illness: <i>370 Multiple Injuries</i>	
13. Training Deficiencies Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>			
14. Company of Employment: (If different from production operator) <i>Operator</i>		Independent Contractor ID: (if applicable)	
15. On-site Emergency Medical Treatment Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input checked="" type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)		17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>	

**Victim Information: 8**

1. Name of Injured/III Employee: <i>Casey T. Metcalf</i>	2. Sex <i>M</i>	3. Victim's Age <i>22</i>	4. Degree of Injury: <i>03 Days away from work only</i>
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:		6. Date and Time Started: <i>a. Date: 08/16/2007 b. Time: 6:00</i>	
7. Regular Job Title: <i>012 Roof Bolter</i>	8. Work Activity when Injured: <i>083 Setting Props</i>		9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>X</b>
10. Experience a. This Work Activity: <i>0 1 2</i>	b. Regular Job Title: <i>0 1 4</i>	c. This Mine: <i>0 1 4</i>	d. Total Mining: <i>1 21 2</i>
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>		12. Nature of Injury or Illness: <i>370 Multiple Injuries</i>	
13. Training Deficiencies Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>			
14. Company of Employment: (If different from production operator) <i>Operator</i>		Independent Contractor ID: (if applicable)	
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input checked="" type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)		17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>	

**Victim Information: 9**

1. Name of Injured/III Employee: <i>Lester A. Day</i>	2. Sex <i>M</i>	3. Victim's Age <i>49</i>	4. Degree of Injury: <i>03 Days away from work only</i>
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:		6. Date and Time Started: <i>a. Date: 08/16/2007 b. Time: 6:00</i>	
7. Regular Job Title: <i>001 Beltman</i>	8. Work Activity when Injured: <i>083 Setting Props</i>		9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>X</b>
10. Experience a. This Work Activity: <i>0 1 2</i>	b. Regular Job Title: <i>2 24 0</i>	c. This Mine: <i>2 24 0</i>	d. Total Mining: <i>14 0 0</i>
11. What Directly Inflicted Injury or Illness? <i>122 Side or Rib</i>		12. Nature of Injury or Illness: <i>370 Multiple Injuries</i>	
13. Training Deficiencies Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>			
14. Company of Employment: (If different from production operator) <i>Operator</i>		Independent Contractor ID: (if applicable)	
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input checked="" type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)		17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>	

Accident Investigation Data - Victim Information

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



Event Number: 4 0 1 1 3 6 1

**Victim Information: 4**

1. Name of Injured/Ill Employee: Jeff Tripp  
 2. Sex: M  
 3. Victim's Age: 40  
 4. Degree of Injury: 03 Days away from work only

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:  
 6. Date and Time Started: a. Date: 08/16/2007 b. Time: 12:45

7. Regular Job Title: 049 Foreman  
 8. Work Activity when Injured: 083 Setting Props  
 9. Was this work activity part of regular job? Yes No  X

10. Experience: a. This Work Activity: 0 0 1 b. Regular Job Title: 0 0 1 c. This Mine: 0 0 1 d. Total Mining: 10 0 0

11. What Directly Inflicted Injury or Illness? 122 Side or Rib  
 12. Nature of Injury or Illness: 370 Multiple Injuries

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)

**Victim Information: 5**

1. Name of Injured/Ill Employee: Frank E. Markosek  
 2. Sex: M  
 3. Victim's Age: 57  
 4. Degree of Injury: 03 Days away from work only

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:  
 6. Date and Time Started: a. Date: 08/16/2007 b. Time: 14:00

7. Regular Job Title: 095 MSHA Inspector  
 8. Work Activity when Injured: 083 Setting Props  
 9. Was this work activity part of regular job? Yes No  X

10. Experience: a. This Work Activity: 0 1 2 b. Regular Job Title: 36 0 0 c. This Mine: 0 0 0 d. Total Mining: 36 0 0

11. What Directly Inflicted Injury or Illness? 122 Side or Rib  
 12. Nature of Injury or Illness: 370 Multiple Injuries

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

14. Company of Employment: (If different from production operator) Mine Safety and Health Administration  
 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:

**Victim Information: 6**

1. Name of Injured/Ill Employee: Joseph R. Bouldin  
 2. Sex: M  
 3. Victim's Age: 37  
 4. Degree of Injury: 03 Days away from work only

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:  
 6. Date and Time Started: a. Date: 08/16/2007 b. Time: 6:00

7. Regular Job Title: 050 Shuttle Car Operator  
 8. Work Activity when Injured: 083 Setting Props  
 9. Was this work activity part of regular job? Yes No  X

10. Experience: a. This Work Activity: 0 1 2 b. Regular Job Title: 0 1 4 c. This Mine: 0 1 4 d. Total Mining: 1 7 2

11. What Directly Inflicted Injury or Illness? 122 Side or Rib  
 12. Nature of Injury or Illness: 370 Multiple Injuries

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)