

DIVISION OF INDUSTRIAL RELATIONS  
 DEPARTMENT OF BUSINESS & INDUSTRY  
**MINE SAFETY & TRAINING SECTION**  
 400 W. King Street, Suite 210  
 Carson City, NV 89703  
 Email: mines@dir.nv.gov  
 775-684-7085

Immediate Notification of an Accident  
 must be made by telephone to the  
 Carson City office in addition to the  
 completion of this form.

MSHA ID NO. \_\_\_\_\_ CONTRACTOR ID NO. \_\_\_\_\_

Mine Name \_\_\_\_\_ Company Name \_\_\_\_\_ County \_\_\_\_\_

Accident Information:

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ Time Shift Started \_\_\_\_\_

Month Day Year  am  am  
 pm  pm

Where in or at the Mine did the accident occur \_\_\_\_\_

Check if Underground Mine  Check if Surface Mine or Other

Name of Injured Employee \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female

Experience	Years	Weeks
This job title		
At this Mine		
Total Mining Experience		

Job Title \_\_\_\_\_

Employee Work Activity when Injury or Illness occurred \_\_\_\_\_

Name of Immediate Supervisor \_\_\_\_\_ Telephone Number \_\_\_\_\_

Describe the conditions contributing to the Accident/Injury and damage or impairment to individual:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Part of Body Injured or Affected \_\_\_\_\_

Check if injury resulted in death  
 Check if injury resulted in permanent disability  
 (Include amputation, loss of use & permanent total disability)

Equipment Involved \_\_\_\_\_ Type \_\_\_\_\_ Manufacturer \_\_\_\_\_ Model # \_\_\_\_\_

Name of Witness to Accident/Injury \_\_\_\_\_ Job Title \_\_\_\_\_

Date returned to work at full capacity \_\_\_\_\_ Number of Days Away \_\_\_\_\_ Number of Days Restricted \_\_\_\_\_

Month Day Year from work \_\_\_\_\_ Work Activity \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Title \_\_\_\_\_

Date Report Prepared \_\_\_\_\_ Area Code and Phone Number \_\_\_\_\_

(month, day, year)

**MAIL, FAX OR EMAIL THIS FORM TO MINE SAFETY & TRAINING** 400 W. KING STREET, SUITE 210 CARSON CITY, NV 89703