



**STATE OF OKLAHOMA
DEPARTMENT OF MINES**

405-427-3859 Office
405-424-4932 Fax

2915 N. Classen Blvd, Suite 213

Oklahoma City, OK 73106

ACCIDENT REPORT

Reported Accident (check one):

Non-Fatal

Fatal

Company Name: _____ Date of Accident: _____

Company Mailing Address: _____ Time of Accident: _____

State Permit Number: _____ Mine Name: _____ Location of Accident: _____

Name of Injured Person (Employee): _____ Employee Job Title: _____

Employee Mailing Address: _____

Employee Age: _____ Employee Date of Birth: _____

Number of years employee has worked in mining industry: _____

Length of employment in present position: _____

Accident occurred (check one) Surface Underground*

If accident occurred underground, please provide the following information:

Entry Number: _____ Room Number: _____ Other: _____

Accident caused (check one): Lost Time No Lost Time

If lost time, estimated length of disability: _____

Nature of Accident (describe injuries): _____

Cause of Accident (give full particulars and recommendations against repetition): _____

**All underground accident reports must be completed and mailed to Oklahoma Department of Mines within ten (10) days of accident.*

Signature of Company Official

Signature of ODM Inspector