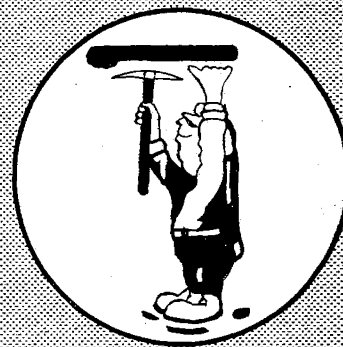
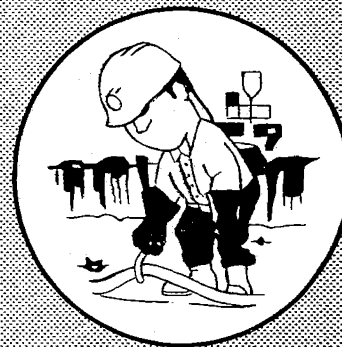


April 1979



BULLETIN



United States Department of Labor

MSHA

Mine Safety and Health Administration

April 1979

CONTENTS

1. Notice, "Hurry, Hurry, Hurry" - Announcing Annual Meeting of the Holmes Safety Association, May 9, 1979
2. Notice to members of the Holmes Safety Association
3. Safety Topic, "Suggested Guidelines for Accident Investigation (Fatal and Nonfatal)"
4. Safety Topic, "In a Day's Time"
5. Safety Topic, "The Last Word"
6. Meeting Report Form

April 1979

HURRY...HURRY.....



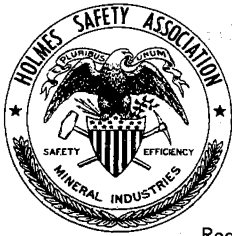
HURRY!

**ANNUAL MEETING OF THE H.S.A.
WILL BE HELD IN ROOM N.5437,
A,B,AND C, U.S. DEPT. OF LABOR
BLDG, 200 CONSTITUTION AVE,
N W., WASHINGTON, D.C. 20210
WEDNESDAY, MAY 9, 1979, 10 a.m.**

**THE J.A.H.S.A. WILL MEET SAME
TIME AND PLACE THE
FOLLOWING DAY.**

NATIONAL SECRETARY

President
ROBERT E. BARRETT
Windber, PA



Room 7K
301 W. Congress St.
Tucson, AZ 85701
Telephone: (602) 792-6631



MINE SAFETY AND HEALTH ADMINISTRATION

HOLMES SAFETY ASSOCIATION

Secretary-Treasurer
WILLIAM H. HOOVER
Tucson, AZ



Four Parkway Center
Suite 102
Pittsburgh, PA 15220
Telephone: (412) 922-0220

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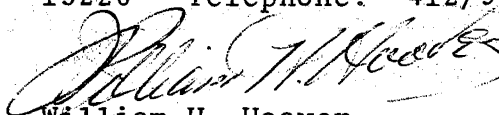
April 1979

TO: MEMBERS

This monthly topic is a re-release that was in popular demand in 1975.

Its contents are informative and direct and will certainly help to improve your accident-prevention programs.

When requesting additional copies, write or telephone: U.S. Department of Labor, MSHA, Office of Holmes Safety Association, Four Parkway Center, Suite 102, Pittsburgh, Pa. 15220 - Telephone: 412/922-0220.


William H. Hoover
National Secretary
Holmes Safety Association

April 1979



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Suggested Guidelines for Accident Investigation

(Fatal and Nonfatal)

The failure of many employees to report minor injuries is indeed a problem that confronts supervisors and one that requires good relations to reduce such nonreporting to an absolute minimum.

Safety-conscious supervisors realize that every accident, regardless of its extent and type, carries with it a lesson to be learned and that every unreported accident reduces the potential for an injury-free industry. There is not even the assurance that the employee who was injured and then failed to report the accident learned anything.

The following reasons are given why failure to report such injuries is a major problem:

1. Infection of untreated injuries may result. Each year the medical profession has cause to treat serious infections that developed from failure to report minor injuries and receive proper medical treatment. So-called minor injuries often develop into injuries of major proportion resulting in loss of working time for the employees and considerable expense to employers.
2. Aggravation of injuries may result. Quite often, employees will judge the severity of an injury by the amount of pain it produces, which can be very misleading. Numerous cases have been recorded where injuries, such as bone chips or small fractures have

(For underground and surface mining operations)

been ignored by employees, because no great amount of pain was involved or there was no open wound.

3. Nothing is learned from unreported accidents. The facts of an accident should be regarded as potential lessons for both supervisor and employees. The supervisor has no opportunity to determine the cause if the employee fails to report a minor injury, thereby impairing ability to prevent similar accidents, possibly of a more serious nature, at a later date.

4. Other injuries may result from the same cause. The correction of causes of unreported minor injuries cannot, of course, be accomplished, and a trap is thus left baited to produce a possible disabling injury or fatality.

5. The practice may become general. The influence of the persons not reporting the minor injuries may very well carry over to other employees in the crew and could soon spread over the entire mine. This situation results in the loss of considerable information about accidents, and disabling injuries will increase, since the causes of accidents are not corrected.

Why do some employees fail to report minor-injury accidents? The reasons vary with individuals, but it is contended by competent authorities that many minor-injury accidents can be traced to mannerisms of supervisors when such accidents are reported. Some of the major reasons for not reporting such accidents are as follows:

1. Fear of supervisor's disapproval
2. Regard injury as trivial
3. Not wanting to lose time from job

4. Not wanting an accident on their record
5. Reluctant to spoil a unit record
6. Afraid of possible discipline
7. Do not realize importance of proper treatment for minor injuries.
8. Do not fully understand the reasons why they should report minor injuries.

As a supervisor, there are several things you can do to encourage employees to report minor injuries. Following are four procedures that can aid in solving this problem:

1. Stress the importance of reporting all accidents, no matter how small, and explain why it is necessary. Emphasize the idea that nothing can be learned from an unreported accident.
2. Do not let your manner discourage employees from reporting minor injuries. Never "make light" of an injury that is reported, and never embarrass a person by acting irritated. Be positive in your actions, and let the person know that it was the right thing to do by reporting the accident to you.
3. At frequent intervals, discuss the reporting of all accidents with your employees, reminding them of the reasons why such accidents should be reported. (Cite an example, if possible, of a serious infection or aggravation of injury case that resulted from failure to get prompt medical attention.)
4. Show your disapproval of delayed cases. Let it be known that you disapprove of any failure to report promptly, even a minor injury. Emphasize that failure to report injuries is not acceptable, and explain again why all injuries must be reported promptly.

A delayed injury report does not always mean that the employee has been negligent, since some injuries have a delayed effect. It should only be considered a neglected case when there is good reason to believe that the employee was aware of the injury but failed to report promptly.

Elements of an Accident Investigation

Many supervisors believe that an accident investigation is simply a matter of getting and reporting an employee's story about his accident, which reduces this type of investigation to a mechanical routine. Getting and reporting an employee's version of his accident is only a part of a properly conducted investigation, which also includes the supervisor's evaluation of all available facts and opinions gathered from all sources.

An accident investigation is a concentrated effort to establish all pertinent facts and opinions regarding how and why an accident developed. Naturally, information is obtained from all available sources by considering the elements of the accident: How, who, when, where, and why. The facts, as gathered, are evaluated as to their soundness and feasibility. A report of the accident is then reported with the investigator's judgment of what happened, how it happened, why it happened, and what must be done to prevent similar accidents in the future.

Purpose of an Accident Investigation

There are two mistaken viewpoints of the purpose of an accident investigation that need to be explored. The first opinion sees the investigation as a means of completing an accident

report form. This opinion downgrades the investigation to a superficial action, and any information gathered is usually just enough to complete the form and, therefore, serves no useful purpose to anyone. The second mistaken opinion is that the accident investigation is merely one to find out whom is to blame. The irony of this opinion is that, usually, the injured person is to blame for the accident, and nothing constructive develops from an investigation of this nature.

The constructive and only real purpose of an accident investigation is to establish all pertinent facts and opinions in order to establish how and why an accident occurred in order that constructive conclusions can be made to prevent a recurrence.

Who Should Conduct Accident Investigations?

The responsibility of investigating accidents concerns all levels of management, but there is a division of responsibility. The immediate supervisor has the primary responsibility of investigating accidents involving employees reporting to him. Following are three good reasons why a frontline supervisor should investigate all accidents that occur under his supervision:

1. He is the individual best qualified for the job.
2. He learns about the causes of accidents.
3. He must apply most of the corrective action.

Who is better qualified to investigate an accident than the immediate supervisor, since it is he that has more first-hand knowledge of the employees and working conditions than anyone

else, due to his daily contact? He knows the details of the job, the conditions and hazards, as well as the unsafe practices that may occur.

The immediate supervisor knows, due to his daily contact with his employees, their language, their personal characteristics, their abilities and skills, and their general attitude. This knowledge enables him to better evaluate their answers to questions, and he is also in a better position to get more truthful answers than other supervisors or department heads.

The investigation of an accident affords the immediate supervisor an opportunity to learn much about accidents and what causes them: Unsafe conditions and causes of such conditions and unsafe practices and personal-factor causes of these practices. The supervisor can spot these conditions, practices, and causes, and then correct them before other accidents develop.

As a result of an investigation, corrective measures are taken to prevent a recurrence, and, quite naturally, it is the responsibility of the frontline supervisors to see that such actions are introduced to his crew members and then followed. Where he was not included in the investigation of an accident, the supervisor might fail to see the necessity of corrective actions and only passively instruct or reinstruct his employees and then neglect to follow through on his actions. The immediate supervisor must be included in the investigation, if positive results are to be forthcoming in reducing accidents.

Accident Facts

A major problem confronting a supervisor in talking with an injured employee concerning facts of an accident is getting the employee to cooperate by telling exactly what happened and how it happened. The accuracy of the accident report will depend, to a great measure, on the individual's willingness to give the facts as he knows them. There are many reasons why an employee may be hesitant to give a true and factual account of the episode, some of which are listed below:

1. Fear of ridicule or of creating a bad impression
2. Fear of discipline
3. Might jeopardize employee's right to compensation
4. Embarrassment

The investigator of an accident should conduct himself in such a manner that the employee will be willing to cooperate by telling what he or she knows and to allay any fears that they might have; otherwise only untruths and half-truths will be forthcoming. Attempting to give an employee a "hard time" will only cause the injured to distort the facts, and nothing constructive will result from the investigation.

Every supervisor has his own individual techniques of getting the facts of an accident, but a general pattern is as follows:

1. Remind the employee of the purpose of the investigation
2. Ask the employee's version of what happened and how it happened.
3. Ask specific questions.
4. Check your understanding of the facts.
5. Discuss means to prevent recurrences.

In discussing an accident with an injured employee, emphasize at the outset that the purpose of the investigation is to prevent injuries of a simliar nature in the future, regardless of who is performing a job. Assure the employee that all the facts must be known and fully understood if you are to discharge your duties as a supervisor in helping to prevent accidents. The employee must have your confidence and should be reassured that your purpose is constructive only and not to blame someone for the accident.

If possible, the employee should be interviewed at the scene of the accident, which will make the explanation much easier for the employee. Many employees have difficulty in expressing themselves unless they can point to a location, demonstrate a procedure, or relate, in some manner, things difficult to explain.

Important points to remember while the employee is giving his or her explantion are: Do not interrupt unless it is absolutely necessary. Wait until the employee has finished, if you have a question. An interruption could break the employee's train of thought.

If some points of the employee's description are confusing, ask specific questions concerning these points. Your questions should deal with what the employee was doing, why he or she was doing it, and what happened. Questions should be reserved until the complete story of what happened has been established.

During periods of uneasiness, employees will often mean one thing and say something quite different. For this reason, the

investigator should verify his understanding of the accident by describing the accident to the injured in his own words. Any conflicting points should be corrected by the employee. One point to keep in mind is that it is the investigator's version of the injured's story that is being checked.

The interview should be completed by discussing ways to prevent accidents of a similar nature in the future. The injured should be encouraged to express ideas on how the job might be made safer.

Another word of caution: Do not attempt to write the accident report while you are conducting the interview. The accident report should only be written after you have obtained all possible information from all sources.

Following is a brief review of major points to consider when gathering information concerning an injury:

1. Be concerned about the employee's injury.
2. Emphasize to the employee why the investigation is necessary.
3. Use a friendly approach.
4. Obtain the injured's story before asking questions.
5. Double check your understanding of the story.
6. Listen carefully.
7. Be patient in clearing up any misunderstandings.
8. Do not use sarcasm or threats.
9. Emphasize preventive measures.

Accident Witnesses

When conducting an accident investigation, the types of witnesses you will be concerned with are the direct, or eyewitness,

and the indirect witnesses. The first classification is so-called because the employee saw the accident occur, and the second classification concerns all individuals who have knowledge of circumstances concerning the accident.

Witnesses, both direct and indirect, are prime sources of information and often provide points concerning an accident that will enable the investigator to more fully understand the complete series of events prior to the event which culminated in the final act, the accident.

Witnesses present special problems to the investigator, since some may be hesitant to discuss the accident if they think their information might, in some manner, discredit a fellow worker, while others will withhold information. Some witnesses, with the mistaken idea that they are protecting a friend, will deliberately distort the facts of the accident. The investigator must be aware of these forms of hostility in witnesses and do nothing to further this antagonism. Witnesses need to be reassured, encouraged, and handled with considerable tact and should be interviewed in a manner similar to that of the person who had the accident, keeping in mind the following:

1. Interview witnesses separately, not in groups, and as soon as possible after the accident.
2. Clearly state the purpose of the interview.
3. Develop a complete story of the accident by asking specific questions after the witness' version of the story.
4. Summarize your understanding of the accident by checking with the witness.

Accident Report

The report covering an accident, whether fatal or nonfatal, should, of course, be complete in detail, but concise and written in such a manner that even an individual foreign to the industry would fully comprehend a true picture of the circumstances surrounding the accident.

Many organizations have special forms for listing the particulars of an accident, most of which have about the same format. These forms follow a definite sequence for listing accident information and usually can be completed by a minimum of writing by the investigator. In addition to personal information concerning the injured individual and data concerning the specific injury, the following information is necessary in an accident report:

1. Exact location of accident. The exact location is usually best given in terms of distance and direction from some definite landmark, as, for example, "Face No. 1 entry, 14 right 9 left section, No. 4-c mine; or, 2 east crosscut and 247 drift on the 8100-foot level."

2. What job was the employee doing? This concerns the job to which the employee was assigned. Included also should be a description of actions of others, if any, that caused or contributed to the accident.

3. Was the employee performing regular job? Quite often, circumstances require that an employee be assigned a job different than his regular duties, which presents different hazards and skills.

4. What basic job step was the injured performing? This portion of the report deals with the part of the job that the employee was actually doing when the accident occurred. If, for example, a timbersetter was striking a safety post with an ax preparatory to moving it to a new location, the job step would be "striking safety post with ax."

5. Was the job step a part of the employee's regularly assigned duties? In an effort to be helpful, an employee may "lend a helping hand" to a fellow employee, and in the process of attempting to be helpful, will become injured, usually because of not being thoroughly familiar with the duties.

6. Description of accident. The description of the accident includes the series of events leading up to and including the accident. In many instances, there are unusual circumstances preceding an accident, in which case a background explanation is necessary to give full meaning to the report. Often this background will be a description of the activities, problems, or conditions that took place or existed before the actual accident sequence. For example, if a timbersetter suffered a fractured left ankle by a "rib roll," a description of the cutting and drilling procedures would be in order if these operations caused a brow to be left in place, and evidence of other such practices were prevalent on the section.

Answers to the following questions will aid in describing the accident:

a. What was the employee's position with respect to the surroundings? This should state the position in relation to

those parts of the surroundings which had anything to do with the accident. As an example, "Fifteen feet in by the third loading station and 8 feet from the right rib."

b. In what manner was the employee performing the job step?

One example might be the following: "The employee was striking a safety post with an ax, with back to the right rib."

c. What triggered the accident? Continuing with our example, the following might be written concerning the timbersetter:

"Vibrations produced by the ax striking the post carried into the roof and to the right rib, thereby loosening the overlay, allowing it to fall."

d. How did the accident end? This question refers to the type of accident or the agent of contact, as for example, "Struck by falling coal and/or rock."

e. What did the employee, or some other person, do or fail to do? This is one of the more important questions that you, as an investigator, will need to know in order that possible corrective measures can be evaluated, since it attempts to establish causes of the accident. The answer to this question will be evident if you have written a good description of the accident. You must be specific in stating your answer, which should always be related in terms of actions or omissions that contributed to the accident. In the case of our example, the timbersetter, failing to detect the unsafe condition, contributed to the accident.

f. What were the underlying reasons for the employee's actions?

This question attempts to establish the personal factor-causes of the accident and quite often is difficult to determine. Every

effort should be made to identify these reasons, if possible, and the investigator will have to rely on the individual's knowledge and experience of the job in order to base an opinion if the reasons are not readily apparent. Examples of personal factor causes are: Unaware of job hazards, inattentive to hazards, unaware of safe method, acting to avoid extra effort, defective visions, and influence of emotions. There are others that could be mentioned but the cited examples should be sufficient in aiding the investigator in adding his own personal items to the list.

g. What conditions of the surroundings contributed to the accident? The answer to this question will establish the direct environment cause of the accident, which can usually be traced to tools, equipment, structures, or work area. Environmental causes may have existed before the start of the job, may develop during the performance of the job, or may be the result of the employee's own actions or the actions of others. In the case of the timbersetter, the surrounding condition that contributed to the action was the uneven ribline, namely the coal and/or rock protrusion. Usually, environmental conditions have a direct relation to the accident, as in case of the uneven ribline, but in some instances the relationship is not as obvious. One example of this nature would be a poorly located switch that could cause employees to hesitate before walking the short distance to shut down a machine before attempting repairs.

h. What items were responsible for conditions that contributed to the accident? Knowledge of these reasons will often, if not always, indicate need of corrections to prevent a recurrence of the

conditions. Referring again to the accident of the timbersetter, the items responsible for the overhand or brow could be traced to either the manner in which the mining-machine operator allowed the machine to drift off sight in the placement of the shot holes along the right rib. In this case, maintaining straight ribs would be the proper corrective measures.

Recommendations

The report of any accident is not complete until proper corrective measures have been developed for the prevention of recurrences. In most instances, recommendations will be obvious, becoming readily apparent during the course of the investigation. On some rare occasions, corrective measures may require considerable thought and discussion, and possible legwork. Depending on the circumstances surrounding the accident, the number of measures to be taken may range from one or two to several. Recommendations may vary from reinstruction of the individual involved, reassignment of the individual, improved design or construction, or possibly the job should be studied for a revision of performance procedures. Regardless of the nature of the corrective measures to be introduced, they should be as specific and detailed as possible, with definite and clear-cut instructions. Vague statements, such as, "The employee should be more careful," are meaningless and can do little to prevent accidents. All persons performing similar duties should be advised of these recommendations, otherwise the investigation will have limited benefits.

Sketch of Accident Area

A sketch of the accident area is always helpful, and when possible, should be included in the accident report. Most companies assign the duty of the sketch to their engineering departments, but a preliminary sketch, drawn by you, will aid your immediate supervisors to more fully understand the accident while the investigation is being completed. Unless you are gifted with a talent for sketching, as a frontline supervisor, you would not be expected to submit a sketch as polished and detailed as an experienced draftsman, and for preliminary purposes, a sketch drawn free-hand will be more than adequate. Again, depending on the circumstances, a sketch showing the plan or top view, as well as one showing a side (elevation) view, may be required to supplement your report. The sketch can be drawn to scale, but it is not necessary; however, it should have sufficient measurements to give more clarity to your report.

One procedure for obtaining an underground sketch of an accident is as follows: Locate some reference point near the scene of the accident as your starting point. This can be a survey station number or the center of an intersection. A tape measure, 25 or 50 feet in length, is stretched on the bottom along the approximate centerline of the accident area with the zero of the tape measure at the reference point (station number or center of the intersection.) Progressing along the tape measure toward the actual accident area, record all pertinent data, such as information concerning distances of roof or ground supports and riblines, both right and left, from the centerline, and noting

the distance from the reference point. This procedure is continued until the complete area is measured. When equipment is involved in an accident, dimensions of length, width, and height should be recorded, and the position of the equipment noted relative to the overall accident scene. Other features of the accident scene should be recorded on your sketch, such as positions of eyewitnesses and roof-and-rib abnormalities, if present. It is, of course, easier to delete unnecessary information from a sketch than to attempt to recall to mind some needed data which was missed during the investigation.



April 1979

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

IN A DAY'S TIME----

A LOT OF THINGS HAPPEN DURING A GIVEN PERIOD OF TIME IN THE BODY OF AN ADULT OF AVERAGE SIZE. HERE'S WHAT YOU ACCOMPLISH IN JUST 24 HOURS:

Your heart beats 103,689 times.

You breathe 23,040 times.

You inhale 438 cubic of feet of air.

You eat 3.25 pounds of food.

You drink 2.9 quarts of liquids.

You lose .87 pounds of waste.

You speak 4,800 words.

You move 750 muscles.

Your hair grows .01714 inch.

Your nails grow .00046 inch.

You exercise 7,000,000 brain cells,
more or less.

THINK ABOUT IT--ALL THIS ACTIVITY--AND YOU DO IT AS EASILY AS FALLING OFF A LOG. BUT DON'T. ALL THIS ACTIVITY CAN BE STOPPED PERMANENTLY BY AN ACCIDENT THAT CAN HAPPEN IN A SPLIT SECOND.

ACCIDENTS ARE CAUSED BY PEOPLE. PEOPLE LIKE YOU CAN PREVENT THEM!!!

(For underground and surface mining operations)

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The Last Word

April 1979

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

"E A S T E R"

MENTAL DISTRACTIONS

The name Easter comes from the ancient Anglo-Saxon goddess of spring, Eostre or Ostara, in whose honor an annual spring festival was held. Easter, the greatest festival of the Christian Church, commemorates the Resurrection of Jesus Christ, and the service on this day is the most elaborate of the church year. Many of our Easter customs have come from the spring festival, commemorating Eostre and other pre-Christian spring festivals. Colored eggs and rabbits have come from pagan antiquity as symbols of new life. The Easter Monday egg rolling on the lawn of the White House--a custom of European origin--is said to have been introduced in Washington by Dolly Madison.

During this festive season, Christians again re-affirm that only God has the power to create and destroy life. As believers of this faith, let us not challenge His omnipotence to take life by working fool-hardily and by following the dare of an adventurous thought rather than the teachings of safety.

If you find a person smiling as things go wrong, you may assume he just thought of someone to blame it on.

By the time a person gets to greener pastures, he can't climb the fence.

America is the only country where it takes more brains to make out the tax return than it does to make the income.

Thoughts worth remembering: Half of life is giving in--the other half is giving out. If the going seems easy, you just might be going downhill. A man's worth should be judged by what he does when he needn't do anything.



(Underground and surface mining operations)

There is no end to the things that flash through our minds during the performance of daily tasks. Some pass quickly; others become absorbed--but our concern should be with the problem of becoming lost in thought which is entirely unrelated to what we're doing--not having our mind on what we are doing. Perhaps one answer is for each of us to make a deeper personal analysis of the potential danger to ourselves and others through failure to "keep our mind on what we're doing!"

Think--Alertness Prevents "Hurtness!"

RANDOM THOUGHTS

Most of us know how to say nothing, but few of us know when.

A man who is scared by the shadow of doubt doesn't have a ghost of a chance.

A person shouldn't allow yesterday to use up too much of today.

Some people put out nothing but a chill, and wonder why the world is cold.

DRUNK

DRIVERS.

They bring families
together at funerals.

5000-22
(Rev. 12-78)



HOLMES SAFETY ASSOCIATION
MEETING REPORT FORM

For the month of _____

TOTAL meetings held this month _____

TOTAL attendance this month _____

Chapter Number _____ (See address label, if incorrect, please indicate change.)

(Signature)

(Telephone No.)

(Title)

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CONTENTS

Articles

1. Safety Topic, "Idle and Abandoned Areas"
2. Safety Topic, "Hand and Portable Power Tools"
3. Session LXI, "Federal Mine Safety and Health Act of 1977, Sections 303(d) and 303(e), Preshift and Onshift Examinations"
4. Session XXXIV, "Mandatory Safety Standards, Surface Coal Mines and Surface Work Areas of Underground Coal Mines, Ground Control, Subpart K, Section 77.1000"
5. Abstract, "Fall-of-Ground Accident"
6. Safety Slogan, "Make Safety Shine in Seventy-Nine"
7. Safety Cartoon, "You Gonna Just Stand There?"
8. Safety Topic, "Frostbite - Symptoms, Prevention, and Cure"
9. Safety Topic, "The Last Word"
10. Meeting Report Form