INSPECTORATE DIVISION (MINERALS COMMISSION)
MONTHLY EXPLOSIVES RETURNS

COMPANY: **MONTH:**

TYPE OF EXPLOSIVE	STOCK BEGINNING OF MONTH	RECEIPTS DURING MONTH	TRANSFERS DURING MONTH	QUANTITY USED DURING MONTH	CUM. QUANTITY USED DURING MONTH	STOCK END OF MONTH
Nitroglycerin – based > 60% Strength KG						
BOOSTER (150g)						
BOOSTER (400gm)						
Slurries / Emulsion (Kg)						
Plain Detonators (pieces)						
Electric Detonators (pieces)						
Non-Electric Detonators (pieces)						
Detonating Fuse (metres)						
Safety Fuse (metres)						
Igniter Cords – fast (metres)						
Igniter Cords – slow (metres)						
Igniter Cords Connectors (pieces)						
Detonating Relays (pieces)						
Ammonium Nitrate (Kg)						
Ammonium Nitrate Fuel Oil (Kg)						

For any receipt and transfers complete the table below:

NAME AND ADDRESS OF PERSONS TO WHOM TRANSFERRED	NAME AND ADDRESS OF PERSONS FROM WHOM RECEIVED	QUANTITY TRANSFERRED OR RECEIVED

I HEREBY CERTIFY that this is a true statement of the particulars herein set forth.

Date……..

…….
Signature of Manager
( )

NB: This Return must reach the Chief Inspector of Mines not later than the 15th day of the month Immediately following the end of the period to which the Return relates.

MINES FORM 4b

INSPECTORATE DIVISION (MINERALS COMMISSION)

QUARTERLY LABOUR RETURNS

COMPANY: **QUARTER ENDING**:

OPERATIONS	**Ave. Book Strength during the quarter**				**Ave. No. of Persons working during the quarter**				**Total Man-Hours worked during the quarter**				**Total Man-Shift worked during the quarter**			
	S/S		**J/S**		**S/S**		**J/S**		**S/S**		**J/S**		**S/S**		**J/S**	
SURFACE MINES	**G**	**E**	**G**	**E**	**G**	**E**	**G**	**E**	**G**	**E**	**G**	**E**	**G**	**E**	**G**	**E**
EXPLORATION																
PIT																
WORKSHOP & YARDS																
PROCESSING																
CONTRACTORS																
GENERAL																
TOTAL																

Note: 1. This form is applicable to all employees related to the mining companies operations except head office staff who would be required to complete a different form

2. This return must reach the office of the Chief Inspector on Mines not later than 15th day of the month immediately following the end of the period to which the Return relates.

3. Average Book Strength during the Quarter: This should include all employees active or inactive during the quarter and other personnel such as national service personnel.

4. Average Number of Persons Worked during the Quarter: This should include all employees active during the quarter and other personnel such national service personnel.

5. Total Man-Hours Worked during the Quarter: This should be actual man-hours.

6. Total Man-Shift Worked during the Quarter: This should be the actual man-shifts.

7. S/S – Senior Staff Employees.

8. J/S – Junior Staff Employees. And daily rated employees including casuals

9. G- Ghanaian Employees.

10. E- Expatriate Employees.

I HEREBY CERTIFY THAT THIS IS A TRUE STATEMENT OF THE PARTICULARS HEREIN SET FORTH

DATE….....

.....
SIGNATURE OF MANAGER
( )

INSPECTORATE DIVISION (MINERALS COMMISSION)
MONTHLY ACCIDENT/INCIDENT INJURY STATISTICS

COMPANY **MONTH:**

MONTH	Fatality	First Aid	No. Of LTI Month	LTI year to date	Shifts Lost	Total Injuries	Damage	No. of Employees
January								
February								
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								
TOTAL								

I HEREBY CERTIFY THAT THIS IS A TRUE STATEMENT OF THE PARTICULARS HEREIN SET FORTH

DATE….....

.....
SIGNATURE OF MANAGER

INSPECTORATE DIVISION (MINERALS COMMISSION)
QUARTERLY STATISTICS ON OCCUPATIONAL DISEASES

COMPANY **QUARTER ENDING**

DISEASE	MONTHS			TOTAL
MALARIA				
SEXUALLY TRANSMITTED DISEASE				
CHRONIC OBSTRUCTIVE AIRWAYS				
LOWER BACK PAIN				
MINERS NYSTAGMUS				
MUSCULOSKETAL DISORDERS				
NOISE INDUCED HEARING LOSS				
PNEUMOCONIOSIS e.g. silicosis				
VIBRATION INDUCED WHITE FINGER				
OTHER (Specify):				
TOTAL				

I HEREBY CERTIFY THAT THIS IS A TRUE STATEMENT OF THE PARTICULARS HEREIN SET FORTH

DATE….....

.....
SIGNATURE OF MANAGER

INSPECTORATE DIVISION (MINERALS COMMISSION)

DISABLING WORK INJURY/ILLNESS REPORT FORM

SECTION A – IDENTIFICATION DATA		
Company name	Mine Name	Does Report pertain to a Contractor?
SECTION B – COMPLETE FOR EACH DISABLING WORK INJURY		
1. Degree of Injury (Tick applicable) Fatal ☐ Permanent Total Disability ☐ Permanent Partial disability ☐ Temporary total Disability		
SECTION C – COMPLETE FOR EACH DISABLING WORK INJURY		
1. Name(s) of injured	2. Regular Job title	3. Mine Number / 4. Date of Birth
5. Name(s) of Witness(es) to injury/illness		6. Number of Reportable injuries/illness resulting from this occurrence
7. Date of Accident	8. Time of Accident	9. Time shift started
10. State specific location where work injury occurred		
11. Mining Method (Please state)		
12. Describe fully the Conditions contributing to the Work Injury:		
13. Please state the nature of the Injury/Illness		
14. Please state the Part of the Body Injured or affected		

Please turn over

15. For loss of member (Traumatic/Surgical) please tick the appropriate space.

☐ Two limbs ☐ Arm shoulder ☐ Both hands

☐ All fingers and thumb ☐ Both feet ☐ Arm at wrist

☐ Arms at shoulder ☐ Arm between elbow and shoulder

☐ Arm at elbow ☐ Arm between wrist and elbow

For fingers, thumb and hand tick appropriate box

	THUMB	FINGERS					
						☐	Loss of four fingers and thumb of one Hand
		Index	Middle	Ring	Little	☐	Loss of four fingers of one hand for toe, foot and ankle tick appropriate boxes
Distal Phalange						☐	Loss of toe, all on one foot
Middle Phalange						☐	Loss of toe-treat, one phalanx
Proximal Phalange						☐	Loss of toe-great, both phalanges
Metacarpal						☐	Loss of toe-other than great

16. For loss of use of member please tick the appropriate spaces

☐ Loss of sight one eye ☐ Loss of hearing one ear ☐Total loss of sight

☐Total loss of hearing

17. Occupational illness (Please state which type)

18. Employer's work being performed when injury or illness occurred	19. Experience	YRS	WEEKS
	Experience in the job title		
	Experience at the Mine		
	Total mining experience		

SECTION D – RETURN TO DUTY INFORMATION		**FOR OFFICIAL USE ONLY**
1. During injured/ill employee returned to regular work	3. Days of restricted work activity, if Any -	Serial Number
2. Number of days away from Work -	4. Estimated days of disability -	Accident Classification
SECTION E – SIGNATURE OF THE GENERAL MANAGER/MINE MANAGER		Remarks
Date Report was Prepared		

Mines Form 7 (Revised 1995)