

General Information			
Name of Entity:			
Type of Business Activities:			
Sector Name:	<input type="checkbox"/> Building and Construction <input type="checkbox"/> Food <input type="checkbox"/> Industry <input type="checkbox"/> Waste <input type="checkbox"/> Health	<input type="checkbox"/> Education <input type="checkbox"/> Commercial <input type="checkbox"/> Tourism & Culture <input type="checkbox"/> Transport <input type="checkbox"/> Energy	
Number of Employees:			
Current OSH Resources:	Director / Manager:		Advisor / Officer / Technical / Other:
Contact of Head Office within Emirate:	Address:	Zone : _____	
	Telephone No.:	Coordinates: Northing : _____	
	Fax No.:	Easting : _____	
		E-mail Address:	
		P.O. Box:	
Authorized Contact Person:			
Authorized Contact Person Position / Title:			
Contact Details of Authorized Person:	Telephone No.:	E-mail Address:	
	Fax No. :	P.O. Box :	
Other Offices / Sites / Projects Operating Under this Entity Operating License:	Address:	Coordinates:	
		Zone	Northing
Location Map(s):	<input type="checkbox"/> Location map(s) of Head Office and Branches attached.		

### Schedule of Developing & Implementing of OSHMS

Target Date for Completing the Development of OSHMS:	____ (Day) ____ (Month) ____ (Year)
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### Occupational Health & Safety Management System (OHSMS)

<input type="checkbox"/>	Have an OHSMS in place and certified to OHSAS 18001.
<input type="checkbox"/>	Have an OHSMS in place based on OHSAS 18001 but not certified by third party.
<input type="checkbox"/>	Have an OHSMS in place but not certified by third party.
<input type="checkbox"/>	No OHSMS in place.

Declaration			
<p>I declare that all information provided in this document is true, correct and complete.</p> <p>I understand that if I utilize the service of consultants for OSH MS development and/or implementation that they must be registered to perform this work in the appropriate category as per ADPHC's requirements.</p>			
Signature of the Authorised Contact Person:		Official Stamp :	
Date : (DD/MM/YYYY)			

Official Use
Assigned Classification Code: _____
Assigned Registration Number: _____
Deadline for completing the development of OSHMS: ____ (Day) ____ (Month) ____ (Year)
<p><i>Note: Implementation of the Entity's OSHMS shall commence within 30 days of receiving approval from the concerned SRA.</i></p> <p><i>Note: Incident Reporting Requirements shall commence from the date of nomination / notification.</i></p> <p><i>Note: OSH Performance Reporting Requirements shall commence in the quarter following quarter of approval.</i></p> <p><i>Note: Annual Third Party External Compliance Audit shall be undertaken with (12) twelve months from the date of approval.</i></p>

Relevant Authority Stamp	Entered into Database by:	
	Name:	
	Signature:	
	Date: (DD/MM/YYYY)	____/____/____
	Reviewed by:	
	Name:	
	Signature:	
	Date: (DD/MM/YYYY)	____/____/____