Form G

مركز أبوظبي للصحة العامة
ABU DHABI PUBLIC HEALTH CENTRE

Notification To:		**Notification Date:** (DD/MM/YYYY)	

To be submitted to the concerned Sector Regulatory Authority a) for fatalities within 24 hrs. of incident and b) for other Serious Incidents within maximum of 3 working days from the date of incident.

1. Reporting Entity Information:		**Incident No. (*for official use by SRA*)**	
Name of Entity:			
Sector:		Classification Code:	
Registration Number:			
Address of Entity:			
Authorized Contact Person:		Email Address:	
Telephone Number:		Mobile Number:	

2. Reporting on behalf of a Non-Nominated Contractor *(hired by or working for Entity but not Nominated currently with any concerned SRA/does not fall under any current Sector).*	☐ Yes	☐ No
Name of Contractor:		
Type of Business:		
Address:		

3. Incident Information

DD/MM/YYYY		Time (24 hr):	
Type of Incident:	☐ Fatality	☐ Serious Dangerous Occurrence **Mechanism11Schedule A**	☐ Serious Injury **Mechanism 11Schedule B**	☐ Serious Occupational Illness **Mechanism 11Schedule C**
Other Consequences resulting from this incident	Restricted Workday Case	Medical Treatment Case	First Aid Cases	Equipment / Property Damage

Incident Description: *(Attach additional pages if required)*			
Incident Location on Site:			
Incident Workplace Address:			
Region where incident occurred:	☐ Abu Dhabi	☐ Al Ain	☐ Western region
Applicable Reports:	☐ Police	☐ Medical	☐ Other (Specify)
Attached:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. Injury Type based on Immediate Judgment of the Severity:

The actual severity and consequences of the notified injury based on diagnosis by licensed health care professional and supported by medical report shall be reported in the incident investigation report to the SRA (Form G1) as well as in the entity performance report to the SRA (Form E/E2).

☐ Injury causing the affected person temporarily unable to perform any regular job or restricted work activity on a subsequent scheduled workday or shift

☐ Immediate medical treatment of the injured person(s) as an in-patient in a hospital;

☐ Medical treatment of the injured person(s) within 48 hours of exposure to a substance;

Immediate medical treatment of the injured person(s) for:

☐ fracture *(not including fingers or toes)*	☐ electric shock or electrical burn;
☐ loss of a distinct part or organ of body including the amputation of any part of body;	☐ serious burns due to thermal and chemical agents;
☐ loss of consciousness and/or requiring resuscitation;	☐ entrapment of a body part in machinery / equipment / plant
☐ a serious head injury;	☐ a spinal injury;
☐ a serious eye injury including loss of sight (temporary or permanent);	☐ dislocation of joints
	☐ the loss of bodily function; and

☐ exposure to a hazardous material;	☐ Serious laceration
☐ the separation of skin from any underlying tissue (such as scalping or de-gloving);	☐ Other

5. Injury Severity known at the time of Incident

The actual severity and consequences of the notified injury based on diagnosis by licensed health care professional and supported by medical report shall be reported in the incident investigation report to the SRA (Form G1) as well as in the entity performance report to the respective SRA (Form E/E2).

☐ Fatality
☐ Permanent Total Disability
☐ Permanent Partial Disability
☐ Lost Workdays Injury
☐ Lost Workdays Occupational Illness

6. Injured Person's Personal Details (For Injuries):

In case of an incident with more than one injured person, complete the information for each person using separate forms

Name:		Occupation:	
Relationship with Entity:	☐ Entity Employee	☐ Contractor Employee	☐ Other Person (e.g. Visitor,)
Nationality:		Date of Birth:	
Passport Number:		Length of Service:	__ Years __ Months
Contact Phone Number:		Gender:	☐ Male ☐ Female

7. Actions Taken Immediately after the Incident:

(Attach additional pages if more space is required)

No.	Actions	Responsibility	Status
1.			
2.			
3.			

Declaration by Reporting Entity:

I declare that all information provided in this document is true, correct and complete.

Signature of the Authorized Contact Person :		Official Stamp:	
Date : (DD/MM/YYYY)			

Official Use by SRA

Requires Reporting to ADPHC: ❑ Yes ❑ No	Requires SRA Investigation / Follow-up ❑ Yes ❑ No
Remarks:	

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

	Signature:	