

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   |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|--|------------------------------|-----------------------------|
| <i>(hired by or working for Entity but not Nominated currently with any concerned SRA/does not fall under any current Sector).</i> |  |                              |                             |
| Name of Contractor:  |  |                              |                             |
| Type of Business:  |  |                              |                             |
| Address:   |  |                              |                             |

| 3. Incident Information  |  |  |  |   |
|--|--|--|--|---|
| DD/MM/YYYY   |  |  | Time (24 hr):  |   |
| Type of Incident:  | <input type="checkbox"/> Fatality                        | <input type="checkbox"/> Serious Dangerous Occurrence    | <input type="checkbox"/> Serious Injury                  | <input type="checkbox"/> Serious Occupational Illness |
|  |  | <b>Mechanism 11 Schedule A</b>                           | <b>Mechanism 11 Schedule B</b>                           | <b>Mechanism 11 Schedule C</b>                        |
| Other Consequences resulting from this incident                    | Restricted Workday Case                                  | Medical Treatment Case                                   | First Aid Cases  | Equipment / Property Damage                           |
| Incident Description: <i>(Attach additional pages if required)</i> |  |  |  |   |
| Incident Location on Site:   |  |  |  |   |
| Incident Workplace Address:  |  |  |  |   |
| Region where incident occurred:                                    | <input type="checkbox"/> Abu Dhabi                       | <input type="checkbox"/> Al Ain                          | <input type="checkbox"/> Western region                  |   |
| Applicable Reports:  | <input type="checkbox"/> Police                          | <input type="checkbox"/> Medical                         | <input type="checkbox"/> Other (Specify)                 |   |
| Attached:  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

| 4. Injury Type based on Immediate Judgment of the Severity:  |   |
|--|---|
| <i>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).</i> |   |
| <input type="checkbox"/> Injury causing the affected person temporarily unable to perform any regular job or restricted work activity on a subsequent scheduled workday or shift   |   |
| <input type="checkbox"/> Immediate medical treatment of the injured person(s) as an in-patient in a hospital;  |   |
| <input type="checkbox"/> Medical treatment of the injured person(s) within 48 hours of exposure to a substance;  |   |
| <b>Immediate medical treatment of the injured person(s) for:</b>   |   |
| <input type="checkbox"/> fracture <i>(not including fingers or toes)</i>   | <input type="checkbox"/> electric shock or electrical burn;                         |
| <input type="checkbox"/> loss of a distinct part or organ of body including the amputation of any part of body;  | <input type="checkbox"/> serious burns due to thermal and chemical agents;          |
| <input type="checkbox"/> loss of consciousness and/or requiring resuscitation;   | <input type="checkbox"/> entrapment of a body part in machinery / equipment / plant |
| <input type="checkbox"/> a serious head injury;  | <input type="checkbox"/> a spinal injury;   |
| <input type="checkbox"/> a serious eye injury including loss of sight (temporary or permanent);  | <input type="checkbox"/> dislocation of joints                                      |
|  | <input type="checkbox"/> the loss of bodily function; and                           |
| <input type="checkbox"/> exposure to a hazardous material;   | <input type="checkbox"/> Serious laceration   |

|  |                                |
|--|--------------------------------|
| <input type="checkbox"/> the separation of skin from any underlying tissue (such as scalping or de-gloving); | <input type="checkbox"/> 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).

|   |
|---|
| <input type="checkbox"/> Fatality                           |
| <input type="checkbox"/> Permanent Total Disability         |
| <input type="checkbox"/> Permanent Partial Disability       |
| <input type="checkbox"/> Lost Workdays Injury               |
| <input type="checkbox"/> 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: | <input type="checkbox"/> Entity Employee | <input type="checkbox"/> Contractor Employee | <input type="checkbox"/> Other Person (e.g. Visitor,)         |
| Nationality:              |  | Date of Birth:                               |   |
| Passport Number:          |  | Length of Service:                           | __ Years __ Months  |
| Contact Phone Number:     |  | Gender:                                      | <input type="checkbox"/> Male <input type="checkbox"/> 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 :<br>(DD/MM/YYYY)                       |  |                 |  |

**Official Use by SRA**

Requires Reporting to OSHAD:  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:                |  |