



DHCR HSE INCIDENT FORM

DHCR HSE INCIDENT REPORTING FORM

Reference Number: _____
(DHCR HSE office use only)

DUBAI POLICE 999

AMBULANCE 998

DUBAI CIVIL DEFENSE 997

DUBAI MUNICIPALITY 223 23 23

This form is designed to capture all untoward or adverse occurrences and near misses within DHCC freezone. Please send the completed form to the DHCR HSE Department by email Sarah.Mansfield@dhcr.gov.ae, in compliance with DHCR HSE incident policy.

CLASSIFICATION INCIDENT:

| | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Incident | <input type="checkbox"/> Sentinel event | <input type="checkbox"/> Near miss |
| <input type="checkbox"/> Dangerous occurrence | <input type="checkbox"/> Property damage | <input type="checkbox"/> Environment |
| <input type="checkbox"/> Complaint | <input type="checkbox"/> Adverse event | |

DETAILS OF INCIDENT/ ADVERSE EVENT/ NEAR MISS/ DANGEROUS OCCURRENCE/ SENTINEL EVENT:

| | | |
|--|-------|-------|
| Date and time of incident/ near miss: | Date: | Time: |
| Description of exact location where the incident occurred: | | |
| Describe the details of the incident: | | |
| Proposed actions: | | |

NOTIFICATION:

| | | | |
|---|--|---|--|
| <input type="checkbox"/> DHCR - HSE Dept. | <input type="checkbox"/> DHCC Security | <input type="checkbox"/> Dubai Police/Civil Defense | <input type="checkbox"/> Unit Manager |
| <input type="checkbox"/> Dubai Municipality | <input type="checkbox"/> Ambulance | <input type="checkbox"/> Family of Injured | <input type="checkbox"/> Building Property Manager |



CATEGORY OF EVENT

| | | |
|--|---|--|
| <input type="checkbox"/> Manual handling/ Ergonomic | <input type="checkbox"/> Hygiene/ Infection control | <input type="checkbox"/> Biological |
| <input type="checkbox"/> Lighting/ Electrics/ Water/ Leaks | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Equipment/ Defect malfunction |
| <input type="checkbox"/> Property damage | <input type="checkbox"/> Dust/ Noise/ Vibration/ Fumes/ Gas/ Chemical | |
| <input type="checkbox"/> Slip trip fall | <input type="checkbox"/> Needle stick/ Sharp | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Electric shock | <input type="checkbox"/> Burn | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Others | <input type="checkbox"/> Fire | <input type="checkbox"/> Collision/ Motor/ Pedestrian |
| <input type="checkbox"/> Waste | <input type="checkbox"/> Bite - Insect/ Animal/ Pest | |

INTERNAL REPORTING

| | |
|-----------------------|--|
| Full name: | |
| Department/ Facility: | |

BODY PART AFFECTED

| | | | |
|--|---|---|--|
| <input type="checkbox"/> Head/ Face/ Neck | <input type="checkbox"/> Eye (R) (L) | <input type="checkbox"/> Ear (R) (L) | <input type="checkbox"/> Back |
| <input type="checkbox"/> Chest/ Abdomen | <input type="checkbox"/> Shoulder (R) (L) | <input type="checkbox"/> Arm/ Wrist (R) (L) | <input type="checkbox"/> Hand/Finger/Thumb (R) (L) |
| <input type="checkbox"/> Leg/ Knee (R) (L) | <input type="checkbox"/> Ankle/Foot/Toe (R) (L) | <input type="checkbox"/> Others | |

WITNESS

| | | | |
|---|-------------------------------------|----------------------------------|--|
| Full name: | | | |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Age: | Department/ Facility: | |
| Status: <input type="checkbox"/> Employee | <input type="checkbox"/> Contractor | <input type="checkbox"/> Patient | <input type="checkbox"/> Visitor <input type="checkbox"/> Others |
| Additional information: | | | |

| | |
|---------------------------------|--|
| Date form completed: | |
| Date form received by DHCR HSE: | |
| Date form reviewed by DHCR HSE: | |

DHCR HSE RISK ANALYSIS

| | | | |
|-----------------|--------|---------|---------|
| Risk Assessment | | | |
| Low | 1 - 5 | High | 16 - 24 |
| Medium | 6 - 15 | Extreme | 25 |