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| DCOP NF39B Form | Health Information and Quality Authority Designated centres for older people (DCOP) Quarterly notification of incidents * NF39B Any occasion of fire alarm activation |  Health Information and Quality Authority An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte |
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| Section 1. Centre details. |
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| Centre name | |
| Centre ID (OSV) | |
| Unit or ward name (if applicable) | |
| Reporting year | |
| Reporting quarter | Quarter 1 (Jan, Feb, Mar) Quarter 2 (Apr, May, Jun) Quarter 3 (Jul, Aug, Sep) Quarter 4 (Oct, Nov, Dec) |

* Please complete this form with HIQA's notification guidance. You can download the guidance at www.higa.ie

Section 2. Fire alarm equipment activated.

Any occasion other than for the purpose of fire practice, drill or test of equipment.

| # | Reason fire alarm equipment was activated | Date alarm activated | Details of occurrence |
|----|--|----------------------|-----------------------|
| 1. | Automatic detection of fire Automatic detection of smoke False alarm or malicious activation Fire alarm malfunction Manual call point activation such as a red break glass unit Other | | |
| 2. | Automatic detection of fire Automatic detection of smoke False alarm or malicious activation Fire alarm malfunction Manual call point activation such as a red break glass unit Other | | |
| 3. | Automatic detection of fire Automatic detection of smoke False alarm or malicious activation Fire alarm malfunction Manual call point activation such as a red break glass unit Other | | |
| 4. | Automatic detection of fire Automatic detection of smoke False alarm or malicious activation Fire alarm malfunction Manual call point activation such as a red break glass unit Other | | |
| 5. | Automatic detection of fire Automatic detection of smoke False alarm or malicious activation Fire alarm malfunction Manual call point activation such as a red break glass unit Other | | |

Section 3. Declaration.

I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief.

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| Name (print) | |
| Position | Person in charge Authorised signatory for and on behalf of the registered provider |
| Signed | |
| Date | |
| Contact number (during office hours) | |

This form should be either:

- **emailed** to: dcop@hiqa.ie or,
- **posted** to: DCOP Regulatory Support Team, Regulatory Support Services, Health Information and Quality Authority, Head Office, Unit 1301, City Gate, Mahon, Cork, T12 Y2XT.

Telephone no: (021) 240 9300

Email: dcop@hiqa.ie