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|  | **ACCIDENT/INCIDENT REPORTING FORM**  **BUREAU OF HEALTH FACILITIES LICENSING** | | | ***This section is to be completed by the Department***    **Accident/Incident**  **Log Number:** |
| **FACILIITY INFORMATION** | | | | |
| **Date Submitted:** | | | | |
| **Licensed Facility/Service Name**: | | | | |
| **License Prefix**: **Suffix #**: | | | | |
| **Address 1**: | | | | |
| **Address2**: | | | | |
| **City**:       **State**:    **Zip Code**: | | | | |
| **Telephone:**       **E-mail Address:** | | | | |
| **Contact Name:**       **Contact Phone:** | | | | |
| **ACCIDENT/INCIDENT INFORMATION** | | | | |
| **Type of Accident/Incident:** | | | | |
| **Date the accident or incident occurred:** | | | | |
| **RESIDENT/CLIENT/PATIENT INFORMATION** | | | | |
| **Number of residents, clients, or patients directly injured or affected by accident or incident:** | | | | |
| **Resident/Client/Patient #:** | | **Age:** | **Sex:** Female  Male | |
| **Resident/Client/Patient #:** | | **Age:** | **Sex:** Female  Male | |
| **Resident/Client/Patient #:** | | **Age:** | **Sex:** Female  Male | |
| **Resident/Client/Patient #:** | | **Age:** | **Sex:** Female  Male | |
| **Number of employees directly injured or affected by accident or incident:** | | | | |
| **Number of visitors directly injured or affected by accident or incident:** | | | | |
| **Witness Name(s):** | | | | |
| **Was the cause investigated and/or identified?** Yes  No | | | | |
| **Give a brief description of the accident/incident including the location where the accident/incident occurred, cause of the accident/incident and treatment for injury:** | | | | |
| **INFORMATION ON INDIVIDUAL COMPLETING THIS FORM** | | | | |
| **Name of Individual Completing this Form:** | | | | |
| **Title of Individual Completing this Form:** | | | | |
| **Telephone:**       **e-mail:** | | | | |
| **By checking this block, I hereby attest that all information is accurate to the best of my knowledge.** | | | | |
| **MAILING INSTRUCTIONS** | | | | |
| **When completed, send form by one of the following methods**:  **By E-mail at**: [BHFL@dhec.sc.gov](mailto:BHFL@dhec.sc.gov)  **By Fax at**: (803) 545-4212  **By mail at**: SCDHEC, Bureau of Health Facilities Licensing, 2600 Bull Street, Columbia, South Carolina 29201 | | | | |
| **DO NOT ATTACH ANY ADDITIONAL DOCUMENTATION UNLESS REQUESTED BY THE DEPARTMENT** | | | | |