Initial 2/24-Hour Report

Report Type:

☐ 2 hr initial ☐ 24 hour initial

Type of Incident:

☐ Injury of unkown source* ☐ Alleged abuse

Date: _____

Facility: _____

Address: _____

Phone #: _____

Resident's Name: _____

DOB: _____

Room #: _____

Certified Bed: ☐ **yes** ☐ **no**

Type of Injury of Unknown Source: _____

Type of Alleged Abuse:

☐ physical ☐ mental ☐ misappropriation of resident property

☐ verbal ☐ neglect

☐ sexual ☐ involuntary seclusion

Name of Alleged Perpetrator: _____

Date/Time of Reportable Incident:

_____

Brief Description of Reportable Incident:

DHEC
Bureau of Certification/Health Regulation
2600 Bull Street, Columbia, SC 29201
Voicemail: 803-545-4300 Fax: 803-545-4292

*CMS S&C-05-09