|  |  |  |
| --- | --- | --- |
|  | **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**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** |