



Initial 24-Hour Report

Type of Reportable Incident

(please circle one)

Injury of Unknown Source*

or

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, S. C. 29201
Voicemail: 803-545-4300 Fax: 803-545-4292

*CMS S&C-05-09