Date:	
Number of pages INCLUDING FAX sheet:	

FAX

TO	**SC DHEC Health Regulation** Division of Health Provider
FAX #	**Bureau of Licensing** **Fax# (803) 545-4212**
Mailing	2600 Bull Street
	Columbia, SC 29201
Courier	301 Gervais St.
	Columbia, SC 29201

From	
Fax#	
Phone#	
Alternate #s	
Phone#	
Phone#	

INITIAL EVENT NOTIFICATION

Occurrence Date & Day			Time
Resident Name	**SS# Last 4 digits**	**Unit**	**Facility**
Brief description of the incident/report			

Statement: The initial ANE Reporting form or Critical Incident Reporting form will be submitted upon completion. A final report will also be submitted upon completion.

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*If this transmission is incomplete, please call:_____.

SAMPLE