

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			
<p style="text-align: center; font-size: 48px; opacity: 0.3; transform: rotate(-30deg);">SAMPLE</p>			
<p>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.</p> <p>The information contained in this facsimile message is privileged and confidential information intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of information is strictly prohibited. If you have received this facsimile in error, please notify us by telephone or arrange for return of the original documents to us</p>			

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