



South Carolina Department of Labor, Licensing and Regulation

Office of Investigations and Enforcement

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**Board of Nursing
EMPLOYER SUPPLEMENTAL COMPLAINT FORM**

License Name: _____

License Contact Information: _____

License: APRN RN LPN License No.: _____ State of Licensure: _____

**Facility
Information**

Contact: (Address, telephone) _____

Start date and termination/resignation date: (If applicable) _____

As a result of incident(s), what action has been taken:

- Retained Individual Accepted Resignation
- Accepted Resignation In Lieu of Termination Terminated Individual

Were multiple patients involved? Yes No

Date and Time of Incident(s): _____

Location of Incident(s): (Include what part of facility) _____

Type of Facility:

- Ambulatory Care Office-Based Surgery
- Assisted Living Physician/Provider Office or Clinic
- Behavioral Health Other: _____
- Critical Access Hospital
- Home Health Care
- Hospital
- Long Term Care

Were there any policies or procedures in place if incident involved clinical event or procedure or patient condition?

Yes (Please include copies with this form)

Previous discipline history by employer(s), including current employer, for practice issues?

Yes (Please include copies with this form)

Did licensee receive any training directly relating to clinical event or procedure or patient condition involved in the incident? Yes No

Patient Demographics

Were specific patient care issues identified? Yes No (If **No**, then skip this section)

Patient Name: _____

Patient DOB: _____ Patient Gender: Female Male

What happened to the patient? Check all that apply:

- Abuse/Neglect
- Allergic/Anaphylaxis/Transfusion Reaction
- Medication Error
- Equipment Failure
- Death
- Nosocomial (hospital-acquired) Infection
- Treatment Error/Omission
- Patient Fell
- Suicide
- Other: (Please specify) _____
- Unknown

Patient outcome as a result of incident:

- No Harm – An error occurred, but with no harm to the patient
- Harm – An error occurred which caused a minor negative change in the patient’s condition
- Significant Harm – Involves serious physical or psychological injury, specifically including loss of function or limb
- Patient Death – An error occurred that may have contributed to or resulted in patient death

Were other patients involved? If so, please list their names, DOB, and gender:

Name and position of person making the report: _____

Name, title, address, phone number, and email of person who accepts subpoenas for your facility:
