SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

South Carolina Drug Assistance Program
PHARMACY INCIDENT REPORT

Date: _____

Agency Name: _____

Agency Contact Name: _____

Agency Telephone Number: _____

Pharmacy Name: _____

Enrollee Name: _____

Enrollee: Month/Year of Birth: ____/xx/_____ Last 4 of SSN: xxx/xx/_____ DAP ID: _____

Incident Details: Please include a detailed description of the incident, date of incident(s), actions taken and outcome of the incident. You can use additional pages if necessary.

Please fax form to the South Carolina Department of Public Health at (803) 898-0475

Incident Details *(con't)*

South Carolina Drug Assistance Program Pharmacy Incident Report
Instructions – 1852-ENG-DPH

Purpose: This form will be used to report issues or concerns with a DAP-approved pharmacy.

Instructions:

Date: Enter the date the form is being submitted.

Agency Name: Enter the name of the agency submitting the form.

Agency Contact Name: Enter the name of the person submitting the form.

Agency Telephone Number: Enter the agency's telephone number.

Pharmacy Name: Enter the name of the pharmacy the incident occurred at.

Enrollee Name: Enter the enrollee's name.

Enrollee Date of Birth: Enter the month and year of the enrollee's date of birth.

Last 4 of SSN: Enter the last four digits of the enrollee's social security number.

ADAP ID: Enter the enrollee's DAP ID #.

Incident Details: Include a detailed description of the incident, date of incident(s), actions taken and outcome of the incident. You can use additional pages if necessary.