



**SUMMARY OF REQUIREMENTS FOR A LICENSE TO PRACTICE AS A
PHYSICIAN ASSISTANT**

You must follow these instructions to obtain a permanent license to practice as a physician assistant in SC. An applicant shall comply with the following requirements as outlined in Section 40-47-945 of the Physician Assistant Practice Act.

ONLINE ELECTRONIC APPLICATION PROCESS:

Select the appropriate online electronic application you wish to use. One gives you the capability to apply for prescription authority with your license and the other gives you the option to submit at a later date.

Submit completed application with non-refundable application fee of **\$120** for application fee **OR \$160** (\$120 application fee and \$40 Prescriptive Authority application fee) and all required documentation listed.

You will have the opportunity to upload your required documentation at the end of the online application. This includes:

- Notarized Signature Affidavit with a 2"x2" professional photo (Passport Photo)
- Legal documentation for name change, if applicable
- Copy of your valid Drivers License, State Issued ID, Passport or Military ID
- Copy of your social security card
- Copy of your current NCCPA Certificate: Visit www.nccpa.net to obtain "verify certificate" page.
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable
- Application for non-controlled substance prescriptive authority, if applicable
- Prescriptive Authority Application, if applicable
- Controlled Substance Prescriptive Authority Form, if applicable
- Notification of Initial Employment with:
 - Cover Sheet for Scope of Practice
 - Supervision Statement initialed by PA
 - Copy of the applicable Scope of Practice

Have submitted directly to the Board office address above from the issuing agent:

- Certification of Education Form or Official Transcripts
- License Verification from each state medical board that you are currently or have ever been licensed in.
- 3 Letters of Recommendation
- Criminal Background Check (CBC) – See CBC Instruction Sheet

LICENSURE REQUIREMENTS

Section 40-47-945 (A) Except as otherwise provided in this article, an individual shall obtain a permanent license from the board before the individual may practice as a physician assistant. The board shall grant a permanent license as a physician assistant to an applicant who has:

- (1) submitted a completed application on forms provided by the Board;
- (2) paid the non-refundable application fee;
- (3) successful completion of an educational program for physician assistants approved by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor organization;
- (4) successful completion of the NCCPA certifying examination and provide documentation that he or she possesses a current, active, NCCPA Certificate;
- (5) certified that the applicant is mentally and physically able to engage safely in practice as a physician assistant;

- (6) no licensure, certificate, or registration as a physician assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant's practice as a physician assistant;
- (7) good moral character;
- (8) submitted to the Board any other information the Board considers necessary to evaluate the applicant's qualifications;
- (9) appeared before a Board member or designee with all original diplomas and certificates and demonstrated knowledge of the contents of this article. A temporary authorization to practice may be issued as provided in Section 40-47-940 pending completion of this requirement and subject to satisfactory interview as provided below; and
- (10) successfully completed an examination administered on the statutes and regulations regarding physician assistant practice and supervision.

EDUCATION:

Applicant will need to have the Certification of Physician Assistant Education sent in or an official transcript with the conferred date reflected on it.

NCCPA CERTIFICATE:

Applicant must provide a copy of their current/active NCCPA Certificate. Visit www.nccpa.net to obtain "verify certificate" page. Proof of current NCCPA Certificate must contain the expiration date.

INTERVIEW REQUIREMENT:

An interview with an individual board member or board designee is required before a permanent license can be issued. When your application is complete and a temporary license issued, you will be sent information about the interview along with setting up the interview with a board member or board designee. Once approved for permanent licensure you may apply for prescriptive authority.

A temporary license, under certain circumstances, may be issued to applicants who meet all requirements for a permanent license and have filed a completed application. However, a "yes" response to questions on the application may require an appearance before the full committee/board before a temporary license can be issued

VERIFICATION OF OUT OF STATE LICENSURE:

A license verification from every state an applicant is currently or has previously been licensed is required to be sent in directly from the licensing state board. A License Verification Form is provided as a courtesy; however the SC Medical Board will accept an official state license verification form from the issuing state board.

CRIMINAL BACKGROUND CHECK (CBC):

A detailed instruction sheet is attached with information to process this requirement.

LETTERS OF RECOMMENDATION:

You are required to have three letters of recommendations written by three licensed physicians or two licensed physicians and a licensed physician assistant willing to write letters of recommendation to support your application for South Carolina medical licensure. **You must request that each physician listed below write directly to the Board** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina.

NOTIFICATION OF INITIAL EMPLOYMENT:

Although this form is not required for the issuance of a license, it is required before employment begins.

The completed form should be accompanied with the Cover Sheet, Supervision Statement, and Scope of Practice.

PHYSICIAN SUPERVISORS/SUPERVISING PHYSICIAN

The supervising physician is responsible for all aspects of the physician assistant's practice. The supervising physician shall identify the physician assistant's scope of practice and determine the delegation of medical tasks. Supervision must be continuous but must not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where the services are rendered, except as otherwise required for limited licensees. A supervising physician may not supervise more than three physician assistants. Only physicians with permanent unrestricted South Carolina licenses may serve as supervising physicians. A physician who is on probation with this Board may not serve as a primary or alternate supervising physician.

Section 40-47-955(D)(E): A supervising physician may not supervise more than three (3) full-time equivalent physician assistants.

The supervising physician has the option to remove an existing physician assistant or submit a letter to the Board indicating that no more than three (3) full-time equivalent physician assistants will work together at any given time.

ALTERNATE SUPERVISING PHYSICIANS

Alternate supervising physicians are responsible for the physician assistant in the absence of the primary supervising physician. Only physicians with permanent South Carolina licenses may serve as alternate supervising physicians. A physician who is on probation with this Board may not serve as an alternate supervising physician. The application must include the signature(s) of alternate supervisor(s). To add an alternate supervising physician at a later time, the physician assistant must complete the Adding Alternate Physicians Form.

If the primary supervising physician leaves the practice, the PA must stop working until he/she has written approval from the Board for another physician to serve as his/her supervising physician. An alternate supervising physician may not assume this role without approval from the Board.

CHANGE OF SUPERVISING PHYSICIAN

The Change/Additional Primary Supervisor form must be submitted when changing or adding an additional primary supervisor. A signed copy of the scope of practice guidelines must accompany this form.

TERMINATION OF SUPERVISORY RELATIONSHIP

If the supervisory relationship between a physician assistant and the supervising physician is terminated for any reason, the physician assistant and supervising physician shall inform the Board immediately in writing of the termination, including the reasons for the termination. The approval of the practice setting terminates coterminous with the termination of the relationship, and practice shall cease until new scope of practice guidelines are submitted by a supervising physician and is approved by the Board.

SCOPE OF PRACTICE GUIDELINES

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervising physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. Sample scope of practice guidelines are available on the board website: <http://lironline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM>

PRESCRIPTIVE AUTHORITY FOR NON-CONTROLLED AND CONTROLLED SUBSTANCES

Permanent Physician Assistants may apply for two types of prescriptive authority and pay a one-time prescriptive authority application fee of \$40. These forms are located under Application and Forms/Physicians Assistants/Prescriptive Authority Forms on the board's website.

Non-Controlled Substance Prescriptive Authority: Submit Application for Prescriptive Authority (Non-Controlled Substances) with supervising Physician's signature.

Controlled Substances Prescriptive Authority: Submit the Controlled Substance Prescriptive Authority Form along with a copy of the certificate showing successful completion of the course: Continuing Medical Education for Appropriate Prescribing of Controlled Substances for Physician Assistants [15 hours of Category I CME credits].

You may enroll in the board-approved course by calling 843-792-1913 or visit the website: <http://academicdepartments.musc.edu/chp/pa/cme/pac.htm> and register online.

Controlled Substance Registration –Applications for both federal and state registration are available from the Narcotic and Drug Control Division, Dept. of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, (803) 896-0634. You cannot register with the DHEC Bureau of Drug Control until you have received your Expanded Authorization to Prescribe Schedule Controlled Substances Approval Letter from the S.C. Board of Medical Examiners office.

JURISPRUDENCE EXAM:

The jurisprudence exam satisfies the requirement to test your knowledge of the statutes and regulations. When your application is processed, your application status will reflect "exam eligible". You will be able to access the online exam at:

<https://eservice.llr.sc.gov/SecurePortal/Login.aspx?ReturnUrl=%2fSecurePortal%2findex.aspx>.

You must pass with a 70; if you fail you will be able to retest after 24 hours has passed.

Information on exam questions may be found at:

<http://llronline.com/POL/Medical/index.asp?file=laws.htm> in Section 40-47-905 through 40-47-1020.

DO NOT SEND EXAM SCORES TO THE BOARD. The board automatically receives an email of your test scores.

Allow 15 business days for processing before contacting the board regarding the status of your application.

You may check the status of your application by visiting the website at
www.llronline.com/pol/medical



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

P.O. Box 11289 • Columbia, SC 29211

Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515

www.llronline.com/POL/Medical/



Criminal Background Check (CBC) Instruction Sheet

An applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in Section 40-47-36 of the Medical Practice Act.

This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI). These services are provided by Identogo Centers and are operated by MorphoTrust USA.

Residents of South Carolina should go online to schedule for fingerprinting services:

<http://www.identogo.com/FP/SouthCarolina.aspx> or call (866) 254-2366 for assistance in scheduling. Scheduling services will provide detailed information of forms of identification that will be required.

If you are a non-resident of South Carolina and do not reside in an area near South Carolina, please follow the **Non-Resident Card Scan Processing Procedures** below.

Non-Resident Card Scan Processing Procedures

For applicants that reside out of South Carolina who wish to use the Identogo/Morpho Trust USA Centers, you may use these centers that are located in South Carolina only. If an applicant does not reside near South Carolina, they must complete and submit the fingerprint cards by following the directions below. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. The section below details the procedures for submitting fingerprints to the MorphoTrust card scan department. Applicant should contact Identogo/MorphoTrust (866-254-2366) to verify the current fee to submit.

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards.
- Fingerprints may be submitted on FBI applicant cards. The applicant may call or email the Medical Board to have the FBI applicant cards mailed to them. Phone: 803-896-4500 or email: Medboard@llr.sc.gov. Due to agency specific information, MorphoTrust USA does not provide fingerprint cards to applicants.
- Applicant should ensure the fingerprint cards are completely filled out. Required information includes:
 - ORI Number: **SC920110Z**
 - Full Name
 - Home Address
 - Place of Birth (State or Country Only)
 - Citizenship
 - Social Security Number
 - Date of Birth
 - Sex, Height, Weight, Hair Color and Eye Color
 - Reason fingerprinted
- Mail the fully completed card and applicable fee (Include full name of applicant on the check) to:

MORPHOTRUST USA
ATTN: SC Card Scan
3051 HOLLIS DR SUITE 310
Springfield, IL 62704

Follow-up calls and questions on the processing of a fingerprint card should be made directly to Identogo/MorphoTrust at (866) 254-2366 and speak to a customer service representative.

DO NOT return fingerprint card or fingerprint processing fee in with your application or to the Board of Medical Examiners. This will delay the processing of your application.



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

P.O. Box 11289 • Columbia, SC 29211

Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515

www.llronline.com/POL/Medical/



NOTARIZED SIGNATURE AFFIDAVIT

Certifying Statement:

I, _____ being duly sworn, depose and say that I am the person described and identified, and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agents or representatives and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

Signature of Applicant

Print Name of Applicant

Subscribed and sworn to before me this _____ day
of _____ 20____.

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____



(Notary Seal)



CERTIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Proof of successful completion of an educational program for physician assistants that has been approved by the Commission on Accredited Allied Health Programs or its successor organization is required for licensure. Please have this form completed by the school or have an official transcript sent. Transcript must reflect the conferred date of the degree.

Applicant's Information:

Last: _____ Suffix: _____ First: _____ Middle: _____

Student ID: _____ Contact Number: _____

I am applying for a license to practice medicine in the State of South Carolina. Please complete this form and send the original document bearing the institution's official seal to the above listed address.

 Applicant's Signature

 Date

The Medical School is requested to complete this insert and include the school seal along with the Dean's, Registrar's or President's signature.

It is hereby certified that (student name) _____

of (hometown, state or country) _____ attended (full name of school):

_____ from (dates of attendance): _____ to _____

and received a diploma conferring the degree of: _____

and said diploma bears the following date: _____.

(Seal)

 Signature of Dean, Registrar or PA Program Director

 Title

 Date



Notification of Initial Employment

Scope of Practice Guidelines: The guidelines must be practice specific and clearly specify in detail those tasks for which approval is being sought. Board approved scope of practices may be found at: <http://www.llronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM>

Attach with this form the following (These forms are found on the above listed website):

- Cover Sheet for Scope of Practice
- Supervision Statement initialed by PA
- Copy of applicable scope of practice

PHYSICIAN ASSISTANT:

Last Name: _____ Suffix: _____ First: _____ Middle: _____

PRIMARY PHYSICIAN INFORMATION:

Title: M.D. D.O. SC License Number: _____

Last Name: _____ Suffix: _____ First: _____ Middle: _____

Business Name: _____ Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Fax: _____ Email Address: _____

SPECIALTY INFORMATION:

List any certification by ABMS/AOA approved specialty board(s): _____

LOCATION INFORMATION:

List name and location of any hospital or other offices (other than your own) where you request this Physician assistant to assist you:

Hospital/Office	Location:
_____	_____
_____	_____
_____	_____

SCOPE OF PRACTICE:

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervisory physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. The guidelines shall include at a minimum the:

- name, license number, and practice addresses of all supervising physicians;
- name and practice address of the physician assistant;
- date the guidelines were developed and dates they were reviewed and amended;
- medical conditions for which therapies may be initiated, continued, or modified;
- treatments that may be initiated, continued and modified;
- drug therapy, if any, that may be prescribed within the usual scope of the supervising physician's practice; and
- situations that require direct evaluation by or immediate referral to the physician, including Schedule II controlled substance prescription authorization as provided for in Section 40-47-965.

Please note:

Section 40-47-955(D)(E): A supervising physician may not supervise more than three (3) full-time equivalent physician assistants.

The supervising physician has the option to remove an existing physician assistant or submit a letter to the Board indicating that no more than three (3) full-time equivalent physician assistants will work together at any given time.

If the primary supervising physician leaves the practice, the PA must stop working until he/she has written approval from the Board for another physician to serve as his/her supervising physician. An alternate supervising physician may not assume this role without approval from the Board.

CERTIFYING STATEMENT

I hereby certify that the foregoing is correct and true, and I assume responsibility for supervising all tasks performed by my physician assistant under my supervision. It is my responsibility to inform all approved alternate supervising physicians of the responsibilities of supervising my physician assistant.

_____ Primary Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date

(Attach an additional sheet, if needed.)



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

110 Centerview Dr • Columbia • SC • 29210

P.O. Box 11289 • Columbia • SC • 29211

Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515

www.llronline.com/POL/Medical/



**APPLICATION FOR PRESCRIPTIVE AUTHORITY
(NON-CONTROLLED SUBSTANCES ONLY)**

Include one-time \$40 application fee

Physician Assistant Name: _____

I acknowledge, understand, and assume my responsibilities as supervising physician of the above named Physician Assistant for prescriptive authority. I understand that should a Physician Assistant acting under my supervision engage in illegal conduct, I shall be subject to discipline under the Medical Practice Act. I further understand and agree that if the Physician Assistant engages in any unprofessional, unethical or illegal conduct, that I will promptly report such action in writing to the State Board of Medical Examiners of South Carolina.

If the Physician Assistant wishes to prescribe Schedule II-V drugs (as authorized in section 40-47-965), an application for a Controlled Substances registration must be obtained from DHEC-Division of Narcotic and Drug Control for a controlled substance license at (803) 896-0634.

Supervising Physician Signature

Date

Physician Assistant Signature

Date



Controlled Substance Prescriptive Authority Form

Controlled Substances Prescriptive Authority: Submit the Controlled Substance Prescriptive Authority Form along with a copy of the certificate showing successful completion of the course: Continuing Medical Education for Appropriate Prescribing of Controlled Substances for Physician Assistants [15 hours of Category I CME credits].

Controlled Substance Registration –Applications for both federal and state registration are available from the Narcotic and Drug Control Division, Dept. of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, (803) 896-0634. You cannot register with the DHEC Bureau of Drug Control until you have received your Expanded Authorization to Prescribe Schedule Controlled Substances Approval Letter from the S.C. Board of Medical Examiners office.

Pursuant to Section 40-47-965 (B) of the 1976 Code of Laws, amended, this is to confirm under oath and penalty of law that I have completed the requirements of the South Carolina Board of Medical Examiners regarding the authorization of licensed Physician Assistants in South Carolina to prescribe Controlled Substances in Schedules II-V.

I hereby certify that I am duly licensed in South Carolina as a Physician Assistant based upon current certification by the NCCPA, which includes not less than 60 contact hours of pharmacotherapeutics. I further certify that I have **successfully completed at least 15 contact hours of education in controlled substances acceptable to the Board.** (Documentation of controlled substance education must accompany this form).

I further certify that my scope of practice guidelines include prescribing controlled substances in Schedules II-V (as authorized in section 40-47-965), as approved by my Supervising Physician.

This form shall serve as an addendum to my approved scope of practice guidelines on file with the Board. It is further understood that I must register with DHEC-Drug Control and have a valid DEA number before prescribing any controlled substances.

Physician Assistant (Signature)

Supervising Physician (Signature)

Physician Assistant (Print Name)

Supervising Physician (Print Name)

Date

Date



This Document must be signed by the Physician Assistant and Supervising Physician stating they have read and understand the expanded prescribing privilege for Physician Assistants in South Carolina. **A copy must be kept on file at each practice site.** It must be reviewed biennially to ensure proper prescribing procedures are followed. It is not necessary to send this form back to the Medical Board.

TO: All South Carolina Licensed Physician Assistants and Supervising Physicians

RE: Management of Expanded Prescriptive Authority for Physician Assistants in South Carolina

The following information was developed to help licensed Physician Assistants in South Carolina in their practice of prescribing controlled substances. You must maintain a copy of this document at all practice sites for inspection upon request by the Board of Medical Examiners or its agent. New rules effective March 15, 2006, give Physician Assistants the ability to prescribe controlled substances upon obtaining a DEA number, registering with the South Carolina Department of Health and Environmental Control's Bureau of Drug Control and signing, with their primary supervising physician, the following document approved by the Board. Spaces are provided at the end of this document for your convenience in fulfilling that responsibility.

Management of Controlled Substances Prescriptive Authority for Physician Assistants in South Carolina

The South Carolina Board of Medical Examiners is charged by law to regulate properly the practice of medicine and surgery for the benefit and protection of the people of the State. Many prescribers are asked to appear before the Board because of a lack of information about the management and responsibilities involved in prescribing controlled substances. The typical inadvertent offender is likely to be a prescriber with a sincere attitude and a desire to relieve pain and misery, but who is also pressed for time and prescribes controlled drugs at patient demand over prolonged periods without adequate documentation. Problem prescriptions are often for chronic ailments such as headache, arthritis, vague old injuries, chronic orthopedic problems, backache or anxiety. (Terminal cancer pain management is not a consideration here.)

It is not what you prescribe; rather it is how well you manage the patient's care and document the treatment in legible form. Prescribing matters which come before the Board are almost always related to controlled substances. A majority of instances where licensees have been disciplined by the Board for prescribing practices could have been avoided completely if the steps outlined here were followed.

The Board does not have a list of "**bad**" or "**disallowed**" drugs. Any drug approved by your supervising physician may be prescribed and administered when properly indicated and, conversely, may be harmful or even lethal when used inappropriately. There is no magic formula for determining the dosage and duration of administration for any drug. Prescribing must be determined within the confines of the individual case and continued under proper monitoring. What is good for one patient may be insufficient or fatal for another. The Board expects licensees to create a record that shows:

- Proper indication and route for the use of drug or other therapy;
- The dosage and volume prescribed (including any refills);
- Monitoring of the patient when necessary or appropriate;
- The patient's response to therapy on follow-up visits;
- Rationale for continuing or modifying the therapy.

STEP ONE - Document an Adequate Examination: First and foremost, before you prescribe anything, start with a diagnosis which is supported by the history and physical findings of the patient being treated and by the results of any appropriate tests. Too many times a licensee must be asked why a particular drug was prescribed. An example of a typical response is, "Because the patient has arthritis." The licensee is asked, "How was that diagnosis reached?" and may answer, "Because that's what the patient complained of." In this example nothing in the record or in the licensee's recollection supports the diagnosis except the patient's assertion. **Do a workup sufficient to support your diagnosis,** including all the necessary studies and/or references to appropriately support the patient's diagnosis.

STEP TWO - Establish a Treatment Plan: Create a treatment plan, which includes the use of non-addictive modalities, if appropriate. Make referrals where appropriate and when included as a part of your written instruction. If referrals are made, the findings of the consultant should be included in the patient's chart.

STEP THREE - Try Conservative Modalities: Before beginning a regimen of addictive or dependence-producing drugs, make a determination through trial or a documented history of a trial that non-addictive modalities are not effective. A finding of intolerance or allergy to non-steroidal anti-inflammatory drugs is one thing, but the assertion of the patient that, "nothing seems to work like that Percodan stuff," is quite another. Many of the practitioners the Board has seen have started a treatment program with powerful controlled substances and did not consider other options or forms of treatment. This may be appropriate in acute settings.

STEP FOUR - Watch out for Drug Seekers: Be wary of the patient who, without adequate clinical symptoms, requests narcotic pain relief. Be alert also to the patient who lists multiple narcotic pain medications to which the requester has allegedly developed allergies and then names another which is well-tolerated. If you know the patient, review the prescription records in the patient's chart and discuss whether the patient has a history of chemical dependency before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum, obtain a verbal drug history, and discuss narcotic or chemical use and family chemical abuse history with the patient. Checking with pharmacies and pharmacy chains may tell you whether a patient is obtaining extra drugs or is prescription shopping.

STEP FIVE - Patient Education: As with any treatment, educate the patient before using a drug that has the potential to cause dependency problems. Take the time to explain the relative risks and benefits of the drug.

STEP SIX - Know the Patient's Environment: The family is a good source of information on behavioral changes, especially dysfunctional behavior. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be symptoms of dependency or addiction. The family is also a good source of information on whether the patient is obtaining drugs from other sources or is self-medicating with other drugs or alcohol.

STEP SEVEN - Monitor the Patient: Maintain regular contact with the patient, including physical monitors. If the regimen is for prolonged narcotic use, a referral for a second opinion may be helpful. It is very important to monitor the patient for the status of the underlying disease, which necessitated the drug and for the potential side effects of the drug itself. This is true no matter what type of controlled substance is used or on what schedule it is listed. With certain conditions and certain drugs, a drug holiday may be appropriate. This could allow you to check the original symptoms during a time when the drug is not given, indicating continuing need for the drug or signaling that the duration of therapy has met its goal and that the medication may be discontinued.

STEP EIGHT - Control the Supply: Make sure you are in control of the supply of the drug. To do this, you must keep detailed records of the type, dose and amount of the drug prescribed. Some practitioners issue only written prescriptions and use multiple copy scripts or photocopies. You must also monitor, record and personally control refills. Do not authorize your office personnel to refill prescriptions. One good way to accomplish this is to require the patient to return to obtain refill authorization. Records of cumulative authorized dosing and average daily dosage can be valuable.

STEP NINE - Maintain Detailed Patient Records: It cannot be emphasized enough that one of the most frequent problems faced by a practitioner when the licensee comes before the Board or other outside review bodies is inadequate records. It is entirely possible that the practitioner did everything correctly in managing a case. Your medical records should be legible and understandable so that any outside reviewer can understand the process which you have followed to manage each patient.

Physician Assistant (Signature)

Supervising Physician (Signature)

Physician Assistant (Print Name)

Supervising Physician (Print Name)

Date

Date

Biennial Review Record

The Physician Assistant and Supervising Physician reviewed the preceding document on the following dates:

<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature
<hr/> Date	<hr/> Physician Assistant Signature	<hr/> Supervising Physician Signature



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. I am a United States citizen; or

2. I am a Legal Permanent Resident of the United States eighteen years of age or older; or

3. I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.

4. Other: _____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____ I-94 Number: _____

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

Signature of Affiant

SWORN to before me this _____ day of _____, 20____

Notary Signature

Print Name

Notary Public for _____

My Commission Expires: _____

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:

If you are a United States Citizen by birth or naturalization

CHECK box 2:

If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:

If you are a Qualified Alien. You are a Qualified Alien if you are:

An alien who is lawfully admitted for residence under the INA.

An alien who is granted asylum under Section 208 of the INA.

A refugee who is admitted to the United States under Section 207 of the INA.

An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.

An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).

An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.

An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.

An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:

Unexpired Reentry Permit (I-327)

Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)

Unexpired Refugee Travel Document (I-571)

Unexpired Employment Authorization Card Which Contains a Photograph (I-766)

Machine Readable Immigrant Visa (with Temporary I-551 Language)

Temporary I-551 Stamp (on passport or I-94)

I-94 (Arrival/Departure Record) in Unexpired Foreign Passport

I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)

DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)



South Carolina Department of Labor, Licensing and Regulation
State Board of Medical Examiners for South Carolina
 P.O. Box 11289 • Columbia, SC 29211
 Phone: 803-896-4500 Fax: 803-896-4515
www.llronline.com/POL/Medical



PHYSICIAN ASSISTANT VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever have been licensed to practice as a physician assistant. You may want to contact each state to see if a fee is required.

In applying for a license to practice as a physician assistant in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature: _____

Name: _____

Address: _____

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____ Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Is license current Yes No If no, why not? _____

Has license been suspended, revoked, or restricted? Yes No If yes, why? _____

Comments, if any: _____

Date: _____

Signature: _____

Print name: _____

Board Seal

Title: _____

Board: _____