



South Carolina Department of Labor, Licensing and Regulation  
South Carolina Board of Medical Examiners

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**NOTIFICATION OF OFF-SITE PRACTICE**  
**(Office location different from that of Supervising Physician)**  
**Physician Assistant Practice Act SECTION 40-47-955**

Before being eligible for off-site practice, the physician assistant must have at least (6) six months of clinical experience with the current supervising physician.

A physician assistant who has at least 2 years continuous practice in the same specialty may practice at a location off-site from the supervising physician after (3) three months of clinical experience with the current supervising physician. This (3) three month requirement may be waived for experienced physician assistants and supervisors upon recommendation of the Committee and approval by the Board.

The off-site location may not be more than (60) sixty miles of travel from the supervising physician or alternate supervising physician without written approval of the Board.

I hereby notify the South Carolina Board of Medical Examiners that I will be practicing as a Physician Assistant at a location off-site from that of my Supervising Physician.

Physician Assistant: \_\_\_\_\_ License Number: \_\_\_\_\_

Supervising Physician: \_\_\_\_\_ License Number: \_\_\_\_\_

Practice specialty of Supervising Physician: \_\_\_\_\_ Nature of practice: \_\_\_\_\_

Primary Office Name/Address: \_\_\_\_\_

Off-Site Practice Name/Address: \_\_\_\_\_

Approximate mileage between off-site practice and primary practice site: \_\_\_\_\_

Number of hours Physician Assistant will work at this location per week: \_\_\_\_\_

Number of hours Supervising Physician will be physically present at this location: \_\_\_\_\_

**Alternate Supervising Physician(s):**

Name: \_\_\_\_\_ S.C License No. \_\_\_\_\_

Name: \_\_\_\_\_ S.C. License No. \_\_\_\_\_

Name: \_\_\_\_\_ S.C. License No. \_\_\_\_\_

Name: \_\_\_\_\_ S.C. License No. \_\_\_\_\_

**Physician Assistant's Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_