



Reactivation Application to Practice as a Physician Assistant

Include with your application:

- Check or money order made payable to LLR-Board of Medical Examiners. Application fee is non-refundable. A returned check fee of up to \$30, or an amount specified by law, **may** be assessed on all returned funds.

Indicate which one:

\$160 for application fee **OR**

\$200 (\$160 application fee and \$40 Prescriptive Authority application fee)

- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Provide a statement to the Board regarding your activity since your license was placed on inactive/lapsed status.
- 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
- 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:

- License Verification from each state medical board that you are currently or have ever been licensed in.
- Criminal Background Check (CBC) – See CBC Instruction Sheet

Note for SC Residents: To find your Congressional District you may go to: <http://www.scstatehouse.gov/legislatorssearch.php>

I. APPLICANT INFORMATION:

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

Have you ever legally changed your name? Yes No Maiden Name: _____

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: _____ City: _____ State: _____ Zip: _____ District: _____
Congressional District (SC Residents Only)

Mailing Address: _____ City: _____ State: _____ Zip: _____
(If different than above)

Phone: _____ Email Address: _____

Business Name: _____ Phone: _____

Fax: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____

NCCPA Certificate Number: _____ Expiration Date: _____

II. RECORD OF LICENSURE

List all states in which you have been licensed in for any medical profession; regardless of status: Active, Inactive, Expired, Training etc. You will need to contact each State Board and request a License Verification to be mailed directly to the Medical Board at the above listed address. We provide a License Verification Form as a courtesy; however, we will accept a state board issued form. Attach additional sheet if needed.

State/Jurisdiction	License No.

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III. MEDICAL PRACTICE EMPLOYMENT HISTORY

List all medically related employment (not training or residency) chronologically, most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert N/A. Attach an additional sheet if needed.

FROM Month / Yr	TO Month / Yr	EMPLOYER NAME	OFFICE ADDRESS	TYPE OF PRACTICE

IV. PERSONAL HISTORY INFORMATION

If you answer yes to any of the below questions, you must attach a full written explanation.

- | | | | |
|----|---|-----|----|
| 1. | Has your physician assistant license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by any licensing board or other entity? | YES | NO |
| 2. | Have you ever had an application to practice as a physician assistant denied or refused by another medical licensing board or other entity? | YES | NO |
| 3. | Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way? | YES | NO |
| 4. | Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration? | YES | NO |
| 5. | Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action? | YES | NO |

- | | | | |
|-----|---|-----|----|
| 6. | Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? | YES | NO |
| 7. | Have you ever had a malpractice lawsuit, judgment filed against you or settled a medical malpractice claim? If yes, how many? _____
(Complete a Malpractice Information Claim Form for each claim) | YES | NO |
| 8. | Are you currently being treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant? | YES | NO |
| 9. | Do you currently have any mental illness (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) or any physical illness or condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant? | YES | NO |
| 10. | Within the past two (2) years, has your ability to practice medicine been impaired by any physical or mental illness or by the use of alcohol and/or drugs? | YES | NO |
| 11. | Have you ever discontinued the practicing as a physician assistant for any reason for three consecutive months or more? | YES | NO |
| 12. | Was your medical education / residency training interrupted other than for vacation periods or military service? | YES | NO |
| 13. | Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity? | YES | NO |
| 14. | Have you ever been convicted, pled guilty or pled nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? | YES | NO |

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

V. 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 as a physician's assistant 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 as a physician's assistant 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

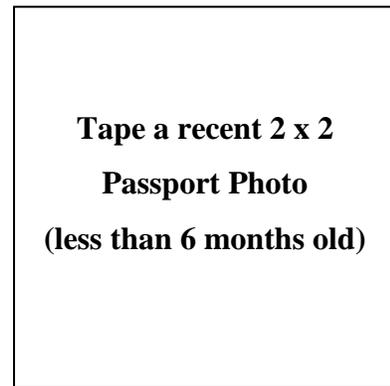
Subscribed and sworn to before me this _____ day
of _____ 20_____.

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____



(Notary Seal)



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

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.



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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



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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:

Date	Physician Assistant Signature	Supervising Physician Signature
Date	Physician Assistant Signature	Supervising Physician Signature
Date	Physician Assistant Signature	Supervising Physician Signature
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Date	Physician Assistant Signature	Supervising Physician Signature
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