



Registered Cardiovascular Invasive Specialists Registration Requirements

A person may not willfully practice or offer to practice as a Cardiovascular Invasive Specialist unless that person is registered by the department. A person who uses the title Cardiovascular Invasive Specialist in any advertisement, business card, letterhead, billing document, anyone who makes verbal or written communication indicating that the person is a Cardiovascular Invasive Specialist or who acquiesces in that representation violates this section.

- (A) Cardiovascular Invasive Specialists may perform medical tasks and services within the framework of a facility's written practice protocol developed for the cardiovascular invasive specialist. Within this practice protocol the registered cardiovascular invasive specialist, under the supervision of a cardiologist may engage in these functions and duties:
- (1) perform baseline patient assessment;
 - (2) evaluate patient response to diagnostic or interventional maneuvers and medications during cardiac catheterization laboratory procedures;
 - (3) provide patient care and drug administration commonly used in the cardiac catheterization laboratory under the direction of a qualified physician and subject to the oversight of the facility;
 - (4) act as the first assistant during diagnostic and therapeutic catheterization procedures; and
 - (5) assist in advanced cardiac life support procedures.
- (B) A Cardiovascular Invasive Specialist shall practice only under the supervision of a physician who is actively and directly engaged in the clinical practice of medicine as a cardiologist.
- (C) A Cardiovascular Invasive Specialist practicing at all sites shall practice pursuant to written scope of the facility's practice protocols signed by all supervising cardiologists and the Cardiovascular Invasive Specialists. Copies of the protocols must be on file at all practice sites. The protocols shall include at a minimum the:
- (1) name, license number, and practice addresses of the supervising cardiologists;
 - (2) name and practice address of the Cardiovascular Invasive Specialists;
 - (3) date the protocol was developed and dates it was reviewed or amended;
 - (4) situations that require direct evaluation by or immediate referral to a cardiologist.
- (D) A Cardiovascular Invasive Specialist may not:
- (1) perform a task which has not been listed and approved on the scope of the practice protocol currently on file with the facility;
 - (2) prescribe drugs, medications, or devices of any kind.

- (E) A Cardiovascular Invasive Specialist must clearly identify himself or herself to ensure that the cardiovascular invasive specialist is not mistaken or misrepresented as a physician. A Cardiovascular Invasive Specialist must wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the Cardiovascular Invasive Specialist's name and the words 'Registered Cardiovascular Invasive Specialist'. Patients in facilities utilizing Cardiovascular Invasive Specialists must be informed when a Cardiovascular Invasive Specialist will be involved in their cardiac care.
- (F) Cardiovascular Invasive Specialists registering with Board must submit the following documentation, this documentation may be uploaded at the end of the application:
- 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)
 - Copy of current Cardiovascular Credentialing International
 - Copy of approved Cardiology Training Program Certificate
 - Malpractice Claim Information Form, if applicable
 - Legal documentation for name change

Please Note:

Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within 15 Business days of the received date.

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After submitting your application, you may check your application status online:

http://llronline.com/index.asp?file=Application_Status_Instructions.html



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

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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 as a registered cardiovascular invasive specialist 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)



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)



MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

Physician Name

Office Telephone No.

Address

City

State

Zip

MALPRACTICE COMPLAINT:

Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.

Patient's Name: _____

Age: _____ Sex: _____ Date of Occurrence: _____

Place of Occurrence: _____

Indicate your position in case (i.e., resident, primary physician, etc.): _____

FILED AGAINST: Individual Doctor Group Hospital

List names of other defendant-doctors and/or hospitals:

DISPOSITION: Pending Jury Verdict Settled Dismissed Dropped

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Total amount paid (if any): _____ Date paid: _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Date: _____ Signature: _____