



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Nursing

P.O. Box 12367 • Columbia, SC 29211

Phone: 803-896-4550 • Fax: 803-896-4515 • www.llronline.com/POL/Nursing/



Advanced Practice Registered Nurse (APRN) – New Employment /Change of Practice Request Form

(§40-33-34 (D) (3) and (H)(4) – APRNs must submit a change of practice form within 15 days of change)

Select type of Advanced Practice that applies to you:

Nurse Practitioner (NP) Certified Nurse-Midwife (CNM) Clinical Nurse Specialist (CNS) Certified Registered Nurse Anesthetist (CRNA)

Last Name		First Name		Middle Name	Maiden Name
Home Address (Street, City, State, Zip):				Home Phone:	
Last five of SSN:		SC License#:		Specialty Area:	
<small>Reminder: All supervising physicians must be within a 45-mile radius and can only supervise up to three (3) NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners. Updates/changes in supervision must be submitted to the Board within 15 days of change. If you have questions, please e-mail NurseBoard@LLR.SC.GOV for assistance.</small>					
<input type="checkbox"/> *New Employment <input type="checkbox"/> Change of Practice Site(s) <input type="checkbox"/> *Change of Physician(s) <input type="checkbox"/> Additional Practice Site(s) <input type="checkbox"/> *Additional Physician(s) <input type="checkbox"/> Remove Physician(s)					
PRIMARY Practice Site <small>(If more than 2 sites, duplicate form as needed)</small>		Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):			
		Practice Address: (Street, City, State, Zip Code)			
<input type="checkbox"/> Primary Supervising Physician <input type="checkbox"/> Alternate Supervising Physician		Supervising Physician (All physicians must have a permanent SC license in good standing)			Proximity to NP, CNM, CNS in Miles:
		Business Address: (Street, City, State, Zip)			
SC Physician's License No:		Practice Specialty:		Primary Practice Site Phone Number	

Signature of Supervising Physician * _____ Date _____
 By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

SECONDARY/ADDITIONAL Practice Site <small>(If more than 2 sites, duplicate form as needed)</small>		Employer Name:			
		Practice Address: (Street, City, State, Zip)			
<input type="checkbox"/> Primary Supervising Physician <input type="checkbox"/> Alternate Supervising Physician		Supervising Physician (All physicians must have a permanent SC license in good standing)			Proximity to NP, CNM, CNS in Miles:
		Business Address: (Street, City, State, Zip)			
SC Physician's License No:		Practice Specialty:		Secondary Practice Site Phone Number	

Signature of Supervising Physician * _____ Date _____
 By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

A copy of practice protocols, for NP, CNM, or CNS/ copy of written approved guidelines for CRNA signed and dated by all the physicians listed above and myself are on file in the office/agency of my employment and available upon request. YES NO

I HEREBY Swear/affirm the statements made in this document to be TRUE to the best of my knowledge.

Signature and Title of Applicant _____		Date _____
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**** Note:** Pursuant to §40-33-34(H)(2)(a)(ii), in addition to the supervising physician or dentist, CRNAs may also have the physician director of anesthesia services or the medical director of the facility sign this form.