SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING & REGULATION
BOARD OF NURSING

110 Centerview Drive, Suite 202, Post Office Box 12367
Columbia, SC 29211-2367

MULTI-STATE LICENSURE PRIVILEGE NOTIFICATION FORM

TO BE COMPLETED BY A NURSE WORKING IN SOUTH CAROLINA ON A LICENSE FROM ANOTHER COMPACT STATE

Please complete, sign, date and return to the address listed above the following information as required in S.C. Code, Section 40-33-1315(D)(3). This information will be used to send you Board information, i.e. newsletters and include you in the workforce studies done to determine the nursing needs in the state.

Name_____

*Social Security #_____ Birth date _____/_____/_____ Sex: ☐Female ☐Male

Race (for statistical purposes only) ☐American Indian ☐African American ☐Caucasian ☐Hispanic ☐Oriental/Asian ☐Other

☐ LPN ☐ RN State of Licensure_____ License No. _____ Expiration Date_____

State of Residence
Address _____Apt #_____

City_____State_____Zip_____

Telephone_____E-mail_____

SC Address _____Apt #_____

City_____State_____Zip_____

Telephone_____E-mail_____Dates of approximate Length of stay in SC: From_____To_____

Primary place of employment in South Carolina

Employer Name_____

City _____ County _____State_____

Zip Code _____Employers Telephone No.(_____)_____Hrs per Week _____

Secondary place of employment in South Carolina

Employer Name_____

City _____ County _____ State _____

Zip Code _____Employers Telephone No.(_____)_____Hrs per Week _____

1. **Indicate all degrees awarded.**

Diploma School of Nursing
01 ☐ _____
Name of School State Yr. Grad.

Associate Degree in Nursing
02 ☐ _____
Name of School State Yr. Grad.

Baccalaureate Degree in Nursing
03 ☐ _____
Name of School State Yr. Grad.

Masters Degree in Nursing
05 ☐ _____
Name of School State Yr. Grad.

Doctorate Degree - ☐ Nursing ☐ Other
08 ☐ _____
Name of School State Yr. Grad.

Baccalaureate Degree other than Nursing
11 ☐ _____
Specify Major

Masters Degree other than Nursing
12 ☐ _____
Specify Major

Nurse Practitioner Certificate Program
06 ☐ _____
Name of School State Yr. Grad.

2. What is your practice status in SC? (Complete one section only)

Employed in nursing as defined in §40-33-20
(Includes direct patient care, teaching, counseling, administration, research, consultation, supervision, delegation, & practice evaluation)

01 ☐ Full Time in SC 02 ☐ Part time in SC 13 ☐ Private Duty in S.C.
18 ☐ Out of State, Specify State or Country_____

3. Indicate your current primary field/setting of employment in SC. (Mark only one)

GENERAL PATIENT CARE

26 ☐ Hospital-Inpatient
27 ☐ Hospital-Outpatient
28 ☐ Hospital Wide (Exclude Codes 16 & 17 below)
02 ☐ Nursing Home (Exclude Codes 18 & 19 below)

PSYCHIATRIC/MENTAL HEALTH

16 ☐ Hospital
19 ☐ Nursing Care Facility
13 ☐ Mental Health Center
20 ☐ Alcohol/Drug Detoxification Ctr or Halfway House

MENTAL RETARDATION

17 ☐ Hospital Unit of Mental Retardation Center
18 ☐ Residential Care Facility (Skilled, ICF, Other)
22 ☐ Non-Residential Care Facility
(e.g. Non-Skilled Day Care, Sheltered Workshop)

OTHER SETTINGS

07 ☐ Physician's Office
11 ☐ Other Office, Specify _____
21 ☐ Free-Standing Outpatient Clinic (e.g. emergency, surgery, dialysis)
08 ☐ Health Department
23 ☐ Private Home Health Agency
25 ☐ Hospice
30 ☐ Faith Comm (Parish) Nurse
12 ☐ Other Community Health, Specify Agency _____
06 ☐ Occupational Health Nursing
05 ☐ School Nurse
03 ☐ School of Nursing
24 ☐ Supplemental Staffing Agency
09 ☐ Self-Employed other than private duty (independent nurse)
04 ☐ Private Duty
29 ☐ Insurer/Third Party Payer
10 ☐ Other, Specify _____

4. Indicate your present major clinical teaching or practice area in SC. (Mark only one)

17 ☐ Home Health
01 ☐ Other Generalized Community Health (e.g. Family Planning, School Health)
09 ☐ Emergency Care
02 ☐ General Nursing Practice
03 ☐ Geriatric Nursing
04 ☐ Obstetrics/Gynecology
22 ☐ Occupational Health
10 ☐ Neonatology
06 ☐ Pediatrics
11 ☐ Critical Care (e.g. ICU, PCU, CCU)
18 ☐ Oncology
13 ☐ Anesthesiology
14 ☐ OR/Recovery Care
20 ☐ Rehabilitation
21 ☐ Dialysis
05 ☐ Other Specialty Medical/Surgery Care
07 ☐ Psychiatric/Mental Health
15 ☐ Mental Retardation/Developmental Disability
16 ☐ Nursing Administration
19 ☐ Outcomes Review (e.g. QA, PRO, Utilization Management)
08 ☐ Other, Specify _____

5. RN/APRN ONLY Indicate the type of position that you presently hold in SC. (Mark only one)

01 ☐ Nursing Administrator/ Director or Assistant
02 ☐ Nursing Consultant
03 ☐ Supervisor or Assistant
04 ☐ Nursing Instructor (Includes In-Service)
05 ☐ Head Nurse or Assistant
06 ☐ Staff/general Duty/Office
07 ☐ CNM (APRN)
10 ☐ CRNA (APRN)
12 ☐ Clinical Nurse Specialist (No Masters Degree-No Medical Acts)
08 ☐ Clinical Nurse Specialist (Master's Level Medical Acts) Certification _____
11 ☐ Clinical Nurse Specialist (Master's Level No Medical Acts) Certification _____
16 ☐ Other, Specify _____
13 ☐ NP (APRN)

Signature_____ Date_____

***** The disclosure of the social security number for identification purposes is authorized and mandated by state and federal statutes. The social security number is not subject to disclosure as public information.