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/

APPLICATION FOR PRESCRIPTIVE AUTHORITY

FEES/ REQUIREMENTS: $20 fee. Submit a check or money order payable to LLR SC Board of Nursing. **Incomplete applications will be returned. Fees are non-refundable.** To meet initial requirements for prescriptive authority, the applicant must provide evidence of 45 contact hours of pharmacotherapeutics. within the past two years from the date of the application and at 15 hours must be in controlled substances. Or, if the applicant is coming from another state with prescriptive authority, 20 contact hours of pharmacotherapeutics is needed and at least 15 hours must be in controlled substances. **See the SC Nurse Practice Act, Chapter 33, Section 40-33-34 (E) for details**. Transcripts must be sent directly from the university to the Board of Nursing. * The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state board to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner (NPDN), among other things.

1. Full Legal Name:_____
   Last First Middle Maiden

2. Mailing Address: _____
   Street City State Zip

3. Home Phone: _____

4. Last five of SSN:_____

5 S.C. License No. _____

6. Practice Specialty: _____

7. **Attach a copy of current national certification.**

8. **Primary Practice /Agency**: _____ Phone: _____

   Address: _____
   Street City State Zip

   All physicians must have a permanent S.C. license which is in good standing. 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).*

9. **Supervising Physician:** _____ **S.C. License No.** _____

   Business Address: _____
   Street City State Zip

   Practice Specialty: _____ County: _____

   Work Phone_____ Proximity to Nurse in Miles: _____

   _____ (Attach Additional Pages for Additional Practice Sites)
   Signature of Supervising Physician*

   Alternate Supervising Physician: _____ **S.C. License No.** _____

   Business Address: _____
   Street City State Zip

   Practice Specialty: _____ County: _____

   Work Phone_____ Proximity to Nurse in Miles: _____

   _____ (Attach Additional Pages for Additional Practice Sites)
   Signature of Supervising Physician*

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

_____ _____
Signature of Applicant *Date*