



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Nursing

110 Centerview Dr. • Columbia • SC • 29210

P.O. Box 12367 • Columbia • SC 29211-2367

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www.llronline.com/POL/Nursing/



2016-2018 APRN RENEWAL APPLICATION

For online renewal go to https://eservice.llr.sc.gov/OnlineRenewals/

APRN License APRN w/Rx Disciplined APRN Disciplined APRN w/Rx (Please check one.)

Name: License Number

Form with sections: Physical Location*, Primary place of employment, Mailing address, Secondary place of employment. Includes fields for Employer Name, Address, City, County, St & Zip, Phone No., and Current hours per week worked.

Please read these instructions carefully:
• Application fee is \$105 for APRN; \$145 for APRN-Rx; \$205 for Disciplined APRN and \$245 for Disciplined APRN-Rx.
• Your current license will expire at midnight 4/30/16, and a 2016-2018 license will be required to continue practicing after this time.
• To ensure your licensure renewal application is processed prior to the expiration date, renew online at https://eservice.llr.sc.gov/OnlineRenewals/ or return your completed form along with proper fees immediately.
• Applications postmarked by 4/30/16 will be processed as regular renewals. After this 4/30/16 date, a reinstatement form and fee is required.

1. Primary Physician Preceptor Name: Primary Physician Preceptor License #
If you are a NP, CNM or CNS, does your primary physician preceptor work within 45 miles of your practice? -or- If you are a CRNA, is your primary physician preceptor onsite?
Alternate Physician Preceptor Name: Alternate Physician Preceptor License #
If you are a NP, CNM or CNS, does your alternate physician preceptor work within 45 miles of your practice? -or- If you are a CRNA, is your alternate physician preceptor onsite?
When does your national certification expire (attach a copy of your national certification)?

2. Prescriptive Authority (If applicable):

I am renewing Prescriptive Authority: Yes No (not applicable to CRNA's)

If yes, I hereby swear/affirm that I have attended the required 20 contact hours of education in pharmacotherapeutics applicable to my specialty, since May 1, 2014, with no more than 15%, three (3) hours, of the total requirement obtained through approved alternative, natural, herbal or complementary pharmacotherapeutics education. I understand that my contact hours are subject to audit by the Board, and I must provide documentation of the same within 72 hours of Board notification. If I am prescribing controlled substances, 2 of the 20 contact hours must be in controlled substances.

I declare my primary state of residence* is: _____

I currently practice in the following states: _____

I currently possess an active license in the following states: _____

I am in the military or federal government and I am currently licensed in _____ (state). I do not intend to work outside of the military or federal government.

3. Since you obtained new licensees, or last renewed your license, have you:

a. Been convicted, pled guilty or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)? **If yes**, attach a detailed explanation letter along with a criminal records check from the state(s) in which you were convicted with your renewal. Yes No

b. Has your license been suspended or revoked or had any other disciplinary action taken by another state nursing board in any jurisdiction? **If yes**, attach a detailed explanation letter with your renewal. Send a request to the board issuing the disciplinary action for a copy of the final order to be sent **directly** to the S.C. Board of Nursing. Yes No

c. Received disciplinary action by any employer for your job performance involving patient care or safety? **If yes**, attach a detailed explanation letter and employer documents with your renewal. Yes No

d. Sustained a physical or mental disability that renders further practice dangerous to the public? **If yes**, attach a detailed explanation letter and a letter from your physician regarding your ability to safely practice nursing with your renewal. Yes No

e. Has there been any change in the status of your lawful presence in the United States since initial licensure? (ie- naturalization; received a renewed permanent resident card) Yes No

I hereby SWEAR / AFFIRM that the statements made on this application to be TRUE to the best of my knowledge.

SC Nursing License Number

Signature

Date

DISCLAIMER

“South Carolina Law requires the agency collect personal information which is only disseminated as required by law. 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 your renewal application and other documents on file 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. In order to better protect the information you provide, please provide the Department with the following information that may be released to the public upon request: a public mailing address, a public email address and a public telephone number.”



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NAME _____ LICENSE # _____

1. INDICATE ALL DEGREES AWARDED:					
DEGREE TYPE	NURSING PROGRAMS			NON – NURSING PROGRAMS	
	SCHOOL NAME / PROGRAM	STATE	YEAR	STATE	YEAR
LPN PROGRAM					
DIPLOMA SCHOOL OF NURSING					
ASSOCIATES					
BACCALAUREATE					
MASTERS					
DOCTORATE					
APRN Certification Prog					

2. Are you currently in a position that requires a Nursing degree: No Yes-Employed Yes-Volunteer

3. What is your current Employment status? (Select One Heading and Sub-Heading)

a. **Employed in nursing:** as defined in 40-33-10F: Includes direct patient care, teaching, counseling, administration, research, consultation, supervision, delegation, & Practice Eval.
 Full-Time in SC Part-Time in SC PRN/Per Diem in S.C. Out of State: (State or Country: _____) Other, specify: _____

b. **Unemployed, not seeking nursing employment:**
 Household responsibilities Student Retired Other, specify: _____

c. **Employed in non-nursing occupation**

d. **Unemployed, seeking nursing employment**

4. Please check here if you would be willing to volunteer your services in the event of a disaster. Yes

5. Please indicate your total number of Nurse Practice Employers: One Two Three or more

Primary employment & practice location (complete section below using "PRI" column)		Secondary employment & practice location (complete section below using "SEC" column)	
Employer Name:		Employer Name:	
Employer Phone #:	Current hours per week:	Employer Phone #:	Current hours per week:
Primary employment Practice/Placement Location Information		Secondary employment Practice/Placement Location Information	
Practice Location Address:		Practice Location Address:	
City:	State:	City:	State:
	Zip:		Zip:
Practice Location County:		Practice Location County:	

NURSING PRACTICE IN SOUTH CAROLINA: Indicate primary employment practice data in "PRI" column, and Secondary employment practice data in

6. Please identify the TYPE(S) OF SETTING(S) that most closely corresponds with your nursing PRACTICE position(s)

PRI	SEC	Description	PRI	SEC	Description	PRI	SEC	Description
<input type="checkbox"/>	<input type="checkbox"/>	110 Academic Setting (Nursing Licensure)	<input type="checkbox"/>	<input type="checkbox"/>	220 Hospice (Inpatient only)	<input type="checkbox"/>	<input type="checkbox"/>	330 Nursing Home/Extended Care
<input type="checkbox"/>	<input type="checkbox"/>	120 Academic Setting (Other instructional areas)	<input type="checkbox"/>	<input type="checkbox"/>	230 Hospital - Emergency Room/Department	<input type="checkbox"/>	<input type="checkbox"/>	340 Occupational Health
<input type="checkbox"/>	<input type="checkbox"/>	130 Alcohol/Drug Detox center	<input type="checkbox"/>	<input type="checkbox"/>	240 Hospital - Inpatient (General/Acute)	<input type="checkbox"/>	<input type="checkbox"/>	350 Physician/Medical Office
<input type="checkbox"/>	<input type="checkbox"/>	140 Ambulatory Care Setting (Other Not Listed)	<input type="checkbox"/>	<input type="checkbox"/>	250 Hospital - Inpatient (eg: ICU, CCU, NICU, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	360 Policy/Planning/Reg./Licensing Agency
<input type="checkbox"/>	<input type="checkbox"/>	150 Ambulatory Surgery Center (Dedicated)	<input type="checkbox"/>	<input type="checkbox"/>	260 Hospital - Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	370 Public Health Dept. (Treatment Location)
<input type="checkbox"/>	<input type="checkbox"/>	160 Assisted Living Facility/Residential Care	<input type="checkbox"/>	<input type="checkbox"/>	270 Hospital - Subacute Care	<input type="checkbox"/>	<input type="checkbox"/>	380 Retail/In-Store clinic
<input type="checkbox"/>	<input type="checkbox"/>	170 Community Health (Other Not Listed)	<input type="checkbox"/>	<input type="checkbox"/>	280 Hospital - Wide (eg: Admin, pool, IT, etc)	<input type="checkbox"/>	<input type="checkbox"/>	390 Rural Health Center
<input type="checkbox"/>	<input type="checkbox"/>	180 Correctional Facility	<input type="checkbox"/>	<input type="checkbox"/>	290 Insurance Company	<input type="checkbox"/>	<input type="checkbox"/>	400 School/College Health Service
<input type="checkbox"/>	<input type="checkbox"/>	190 Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	300 Mental Health Center	<input type="checkbox"/>	<input type="checkbox"/>	410 Urgent Care
<input type="checkbox"/>	<input type="checkbox"/>	200 Federal Clinic (FQHC, VA, MIL, NIH, IHS)	<input type="checkbox"/>	<input type="checkbox"/>	310 MultiSetting(Temporary Placement/Telehealth)	<input type="checkbox"/>	<input type="checkbox"/>	990 Other: (Pri) _____
<input type="checkbox"/>	<input type="checkbox"/>	210 Home Health (inc. Outpat Hospice)	<input type="checkbox"/>	<input type="checkbox"/>	320 NP Provider Clinic (Exclude Retail/In-Store)			(Sec) _____

7. Please identify the employment SPECIALTY(IES)/AREA(S) that most closely corresponds with your nursing PRACTICE position(s)

PRI	SEC	Description	PRI	SEC	Description	PRI	SEC	Description
<input type="checkbox"/>	<input type="checkbox"/>	110 Acute care	<input type="checkbox"/>	<input type="checkbox"/>	220 Emergency/Trauma	<input type="checkbox"/>	<input type="checkbox"/>	330 Oncology
<input type="checkbox"/>	<input type="checkbox"/>	120 Administration	<input type="checkbox"/>	<input type="checkbox"/>	230 Faith Based/Congregational/Parish Nurse	<input type="checkbox"/>	<input type="checkbox"/>	340 Palliative Care/Pain Management
<input type="checkbox"/>	<input type="checkbox"/>	130 Adult Health/Family Health	<input type="checkbox"/>	<input type="checkbox"/>	240 Forensic/SANE	<input type="checkbox"/>	<input type="checkbox"/>	350 Pediatrics
<input type="checkbox"/>	<input type="checkbox"/>	140 Analytics/Outcomes/Quality	<input type="checkbox"/>	<input type="checkbox"/>	250 General Nursing Practice	<input type="checkbox"/>	<input type="checkbox"/>	360 Perioperative
<input type="checkbox"/>	<input type="checkbox"/>	150 Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	260 Geriatric/Gerontology	<input type="checkbox"/>	<input type="checkbox"/>	370 Professional Development
<input type="checkbox"/>	<input type="checkbox"/>	160 Cardiac Care	<input type="checkbox"/>	<input type="checkbox"/>	270 Hospice	<input type="checkbox"/>	<input type="checkbox"/>	380 Psychiatric/Mental Health/Substance Abuse
<input type="checkbox"/>	<input type="checkbox"/>	170 Case Management	<input type="checkbox"/>	<input type="checkbox"/>	280 Informatics	<input type="checkbox"/>	<input type="checkbox"/>	390 Public Health
<input type="checkbox"/>	<input type="checkbox"/>	180 Community	<input type="checkbox"/>	<input type="checkbox"/>	290 Maternal-Child Health	<input type="checkbox"/>	<input type="checkbox"/>	400 Rehabilitation
<input type="checkbox"/>	<input type="checkbox"/>	190 Critical Care	<input type="checkbox"/>	<input type="checkbox"/>	300 Medical Surgical	<input type="checkbox"/>	<input type="checkbox"/>	410 School Health
<input type="checkbox"/>	<input type="checkbox"/>	200 Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	310 Neonatal	<input type="checkbox"/>	<input type="checkbox"/>	420 Women's Health
<input type="checkbox"/>	<input type="checkbox"/>	210 Dialysis/Nephrology	<input type="checkbox"/>	<input type="checkbox"/>	320 Occupational health	<input type="checkbox"/>	<input type="checkbox"/>	990 Other: (Pri) _____ (Sec) _____

8. Please identify the POSITION TITLE(S) that most closely corresponds with your nursing PRACTICE position(s).

PRI SEC	Description	PRI SEC	Description	PRI SEC	Description
<input type="checkbox"/> <input type="checkbox"/>	110 APRN Credential Required - CNM	<input type="checkbox"/> <input type="checkbox"/>	180 Informatics Nurse/Informaticist	<input type="checkbox"/> <input type="checkbox"/>	260 Staff nurse/Direct care/General duty nurse
<input type="checkbox"/> <input type="checkbox"/>	120 APRN Credential Required - CNS	<input type="checkbox"/> <input type="checkbox"/>	190 Nurse Educator (inc. In-Service, Prof. Dev.)	<input type="checkbox"/> <input type="checkbox"/>	270 Supplemental Staffing/Travel/VNS nurse
<input type="checkbox"/> <input type="checkbox"/>	130 APRN Credential Required - CRNA	<input type="checkbox"/> <input type="checkbox"/>	200 Nurse Executive/Administration	<input type="checkbox"/> <input type="checkbox"/>	280 Telehealth nurse
<input type="checkbox"/> <input type="checkbox"/>	140 APRN Credential Required - NP	<input type="checkbox"/> <input type="checkbox"/>	210 Nurse Manager	<input type="checkbox"/> <input type="checkbox"/>	290 Triage/Advice nurse
<input type="checkbox"/> <input type="checkbox"/>	150 Care Coordinator/Case Mgr/Discharge Planner	<input type="checkbox"/> <input type="checkbox"/>	220 Nurse Researcher	<input type="checkbox"/> <input type="checkbox"/>	960 Other - Health Related (Org/Operations Focus):
<input type="checkbox"/> <input type="checkbox"/>	160 Consultant (eg: Legal, Edu., Prac. Standards)	<input type="checkbox"/> <input type="checkbox"/>	230 Patient Educator	<input type="checkbox"/> <input type="checkbox"/>	970 Other - Health Related (Patient Focus):
<input type="checkbox"/> <input type="checkbox"/>	170 Faculty/Professor	<input type="checkbox"/> <input type="checkbox"/>	240 Quality improvement, Utilization Review	<input type="checkbox"/> <input type="checkbox"/>	980 Other - Non-Health Related:
		<input type="checkbox"/> <input type="checkbox"/>	250 School nurse	(Pri) _____ (Sec) _____	

9. APRN ONLY: Are you Currently Practicing as an APRN? (Indicate "Yes" or "Yes, w/ Preceptor" if true for any practice location)

<input type="checkbox"/> 110 YES - CERTIFIED RN ANESTHETIST	<input type="checkbox"/> 130 YES - C. N. S. WITH PRECEPTOR	<input type="checkbox"/> 150 YES - NURSE PRACTITIONER
<input type="checkbox"/> 120 YES - CERTIFIED NURSE MIDWIFE	<input type="checkbox"/> 140 YES - C. N. S. WITHOUT PRECEPTOR	<input type="checkbox"/> 800 NO - RN PRACTICE

10. APRN ONLY: What PERCENT OF YOUR TIME do you spend rendering PRIMARY CARE SERVICES at your practice location?

PRI SEC	Description	PRI SEC	Description	PRI SEC	Description	PRI SEC	Description	PRI SEC	Description	PRI SEC	Description		
<input type="checkbox"/> <input type="checkbox"/>	110 N/A	<input type="checkbox"/> <input type="checkbox"/>	210 1 - 10%	<input type="checkbox"/> <input type="checkbox"/>	220 11 - 25%	<input type="checkbox"/> <input type="checkbox"/>	230 26 - 50%	<input type="checkbox"/> <input type="checkbox"/>	240 51 - 75%	<input type="checkbox"/> <input type="checkbox"/>	250 76 - 90%	<input type="checkbox"/> <input type="checkbox"/>	260 91 - 100%

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