



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

P.O. Box 11289 • Columbia, SC 29211

Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515

www.llronline.com/POL/Medical/



SUMMARY OF REQUIREMENTS FOR A LICENSE TO PRACTICE

You must follow these instructions to obtain a permanent license to practice as a physician assistant in SC. An applicant shall comply with the following requirements as outlined in Section 40-47-945 of the Physician Assistant Practice Act.

LICENSURE REQUIREMENTS

Section 40-47-945 (A) Except as otherwise provided in this article, an individual shall obtain a permanent license from the board before the individual may practice as a physician assistant. The board shall grant a permanent license as a physician assistant to an applicant who has:

- (1) submitted a completed application on forms provided by the Board;
- (2) paid the non-refundable application fee;
- (3) successful completion of an educational program for physician assistants approved by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor organization;
- (4) successful completion of the NCCPA certifying examination and provide documentation that he or she possesses a current, active, NCCPA Certificate;
- (5) certified that the applicant is mentally and physically able to engage safely in practice as a physician assistant;
- (6) no licensure, certificate, or registration as a physician assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant's practice as a physician assistant;
- (7) good moral character;
- (8) submitted to the Board any other information the Board considers necessary to evaluate the applicant's qualifications;
- (9) appeared before a Board member or designee with all original diplomas and certificates and demonstrated knowledge of the contents of this article. A temporary authorization to practice may be issued as provided in Section 40-47-940 pending completion of this requirement and subject to satisfactory interview as provided below; and
- (10) successfully completed an examination administered on the statutes and regulations regarding physician assistant practice and supervision.

EDUCATION:

Applicant will need to have the Certification of Physician Assistant Education sent in or an official transcript with the conferred date reflected on it.

NCCPA CERTIFICATE:

Applicant must provide a copy of their current/active NCCPA Certificate. Visit www.nccpa.net to obtain "verify certificate" page. Proof of current NCCPA Certificate must contain the expiration date.

INTERVIEW REQUIREMENT:

An interview with an individual board member or board designee is required before a permanent license can be issued. When your application is complete and a temporary license issued, you will be sent information about the interview along with setting up the interview with a board member or board designee. Once approved for permanent licensure you may apply for prescriptive authority.

A temporary license, under certain circumstances, may be issued to applicants who meet all requirements for a permanent license and have filed a completed application. However, a "yes" response to questions on the application may require an appearance before the full committee/board before a temporary license can be issued

VERIFICATION OF OUT OF STATE LICENSURE:

A license verification from every state an applicant is currently or has previously been licensed is required to be sent in directly from the licensing state board. A License Verification Form is provided as a courtesy; however the SC Medical Board will accept an official state license verification form from the issuing state board.

CRIMINAL BACKGROUND CHECK (CBC):

A detailed instruction sheet is attached with information to process this requirement.

LETTERS OF RECOMMENDATION:

You are required to have three letters of recommendations written by three licensed physicians or two licensed physicians and a licensed physician assistant willing to write letters of recommendation to support your application for South Carolina medical licensure. **You must request that each physician listed below write directly to the Board** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina.

NOTIFICATION OF INITIAL EMPLOYMENT:

Although this form is not required for the issuance of a license, it is required before employment begins.

The completed form should be accompanied with the Cover Sheet, Supervision Statement, and Scope of Practice.

PHYSICIAN SUPERVISORS/SUPERVISING PHYSICIAN

The supervising physician is responsible for all aspects of the physician assistant's practice. The supervising physician shall identify the physician assistant's scope of practice and determine the delegation of medical tasks. Supervision must be continuous but must not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where the services are rendered, except as otherwise required for limited licensees. A supervising physician may not supervise more than three physician assistants. Only physicians with permanent unrestricted South Carolina licenses may serve as supervising physicians. A physician who is on probation with this Board may not serve as a primary or alternate supervising physician.

Section 40-47-955(D)(E): A supervising physician may not supervise more than three (3) full-time equivalent physician assistants.

The supervising physician has the option to remove an existing physician assistant or submit a letter to the Board indicating that no more than three (3) full-time equivalent physician assistants will work together at any given time.

ALTERNATE SUPERVISING PHYSICIANS

Alternate supervising physicians are responsible for the physician assistant in the absence of the primary supervising physician. Only physicians with permanent South Carolina licenses may serve as alternate supervising physicians. A physician who is on probation with this Board may not serve as an alternate supervising physician. The application must include the signature(s) of alternate supervisor(s). To add an alternate supervising physician at a later time, the physician assistant must complete the Adding Alternate Physicians Form.

If the primary supervising physician leaves the practice, the PA must stop working until he/she has written approval from the Board for another physician to serve as his/her supervising physician. An alternate supervising physician may not assume this role without approval from the Board.

CHANGE OF SUPERVISING PHYSICIAN

The Change/Additional Primary Supervisor form must be submitted when changing or adding an additional primary supervisor. A signed copy of the scope of practice guidelines must accompany this form.

TERMINATION OF SUPERVISORY RELATIONSHIP

If the supervisory relationship between a physician assistant and the supervising physician is terminated for any reason, the physician assistant and supervising physician shall inform the Board immediately in writing of the termination, including the reasons for the termination. The approval of the practice setting terminates coterminous with the termination of the relationship, and practice shall cease until new scope of practice guidelines are submitted by a supervising physician and is approved by the Board.

SCOPE OF PRACTICE GUIDELINES

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervising physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. Sample scope of practice guidelines are available on the board website: <http://lronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM>

PRESCRIPTIVE AUTHORITY FOR NON-CONTROLLED AND CONTROLLED SUBSTANCES

Permanent Physician Assistants may apply for two types of prescriptive authority and pay a one-time prescriptive authority application fee of \$40. These forms are located under Application and Forms/Physicians Assistants/Prescriptive Authority Forms on the board's website.

Non-Controlled Substance Prescriptive Authority: Submit Application for Prescriptive Authority (Non-Controlled Substances) with supervising Physician's signature.

Controlled Substances Prescriptive Authority: Submit the Controlled Substance Prescriptive Authority Form along with a copy of the certificate showing successful completion of the course: Continuing Medical Education for Appropriate Prescribing of Controlled Substances for Physician Assistants [15 hours of Category I CME credits].

You may enroll in the board-approved course by calling 843-792-1913 or visit the website: <http://academicdepartments.musc.edu/chp/pa/cme/pac.htm> and register online.

Controlled Substance Registration –Applications for both federal and state registration are available from the Narcotic and Drug Control Division, Dept. of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, (803) 896-0634. You cannot register with the DHEC Bureau of Drug Control until you have received your Expanded Authorization to Prescribe Schedule Controlled Substances Approval Letter from the S.C. Board of Medical Examiners office.

Allow 15 business days for processing before contacting the board regarding the status of your application.

Application Documentation: The application form is self-explanatory. It sets forth the required information that must be submitted with your application.

You may check the status of your application by visiting the website at www.lronline.com/pol/medical



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Criminal Background Check (CBC) Instruction Sheet

An applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in Section 40-47-36 of the Medical Practice Act.

This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI). These services are provided by Identogo Centers and are operated by MorphoTrust USA.

Residents of South Carolina should go online to schedule for fingerprinting services:

<http://www.identogo.com/FP/SouthCarolina.aspx> or call (866) 254-2366 for assistance in scheduling. Scheduling services will provide detailed information of forms of identification that will be required.

If you are a non-resident of South Carolina and do not reside in an area near South Carolina, please follow the **Non-Resident Card Scan Processing Procedures** below.

Non-Resident Card Scan Processing Procedures

For applicants that reside out of South Carolina who wish to use the Identogo/Morpho Trust USA Centers, you may use these centers that are located in South Carolina only. If an applicant does not reside near South Carolina, they must complete and submit the fingerprint cards by following the directions below. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. The section below details the procedures for submitting fingerprints to the MorphoTrust card scan department. Applicant should contact Identogo/MorphoTrust (866-254-2366) to verify the current fee to submit.

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards.
- Fingerprints may be submitted on FBI applicant cards. The applicant may call or email the Medical Board to have the FBI applicant cards mailed to them. Phone: 803-896-4500 or email: Medboard@llr.sc.gov. Due to agency specific information, MorphoTrust USA does not provide fingerprint cards to applicants.
- Applicant should ensure the fingerprint cards are completely filled out. Required information includes:
 - ORI Number: **SC920110Z**
 - Full Name
 - Home Address
 - Place of Birth (State or Country Only)
 - Citizenship
 - Social Security Number
 - Date of Birth
 - Sex, Height, Weight, Hair Color and Eye Color
 - Reason fingerprinted
- Mail the fully completed card and applicable fee (Include full name of applicant on the check) to:

MORPHOTRUST USA
ATTN: SC Card Scan
3051 HOLLIS DR SUITE 310
Springfield, IL 62704

Follow-up calls and questions on the processing of a fingerprint card should be made directly to Identogo/MorphoTrust at (866) 254-2366 and speak to a customer service representative.

DO NOT return fingerprint card or fingerprint processing fee in with your application or to the Board of Medical Examiners. This will delay the processing of your application.



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Application to Practice as a Physician Assistant

Include with your application:

- Check or money order made payable to LLR-Board of Medical Examiners. Application fee is non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.

Indicate which one:

\$120 for application fee OR

\$160 (\$120 application fee and \$40 Prescriptive Authority application fee)

- Application for non-controlled substance prescriptive authority, if applicable
Copy of your valid Drivers License, State Issued ID, Passport or Military ID
Copy of your social security card
A 2"x2" professional photo (Passport Photo)
Copy of your current NCCPA Certificate: Visit www.nccpa.net to obtain "verify certificate" page
Malpractice Claim Information Form, if applicable
Legal documentation for name change, if applicable
Prescriptive Authority Application, if applicable
Controlled Substance Prescriptive Authority Form, if applicable
Notification of Initial Employment with:
Cover Sheet for Scope of Practice
Supervision Statement initialed by PA
Copy of the applicable Scope of Practice

Have submitted directly to the Board office address above from the issuing agent:

- Certification of Education Form or Official Transcripts
License Verification from each state medical board that you are currently or have ever been licensed in.
3 Letters of Recommendation
Criminal Background Check (CBC) - See CBC Instruction Sheet

Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

I. APPLICANT INFORMATION:

Last Name: First: Middle: Suffix:

Have you ever legally changed your name? Yes No Maiden Name:

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: City: State: Zip: District:
Congressional District (SC Residents Only)

Mailing Address: City: State: Zip:
(If different than above)

Phone: Email Address:

Business Name: Phone:

Fax: Email Address:

Date of Birth: Social Security No.:

Place of Birth (City, State or Country):

Race: Gender: Female Male
(for statistical purposes only)

Name: _____

II. PROFESSIONAL EDUCATION INFORMATION

List in chronological order from date of college graduation all professional education. Do not include continuing education coursework, apprentice, internship, residency, vocational training practical or clinical training. Attach additional sheet(s) if needed.

Institution/Program	LOCATION (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Graduation/Program Completed?	Degree Earned

1. NCCPA Certificate Number: _____ Expiration Date: _____

III. RECORD OF LICENSURE

List all states in which you have been licensed in for any medical profession; regardless of status: Active, Inactive, Expired, Training etc. You will need to contact each State Board and request a License Verification to be mailed directly to the Medical Board at the above listed address. We provide a License Verification Form as a courtesy; however, we will accept a state board issued form. Attach additional sheet if needed.

State/Jurisdiction	License No.	State/Jurisdiction	License No.	State/Jurisdiction	License No.

IV. MEDICAL PRACTICE EMPLOYMENT HISTORY

List all medically related employment (not training or residency) chronologically, most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert N/A. Attach an additional sheet if needed.

FROM Month / Yr	TO Month / Yr	EMPLOYER NAME	OFFICE ADDRESS	TYPE OF PRACTICE

V. PERSONAL HISTORY INFORMATION

If you answer yes to any of the below questions, you must attach a full written explanation.

- | | | | |
|-----|---|-----|----|
| 1. | Has your physician assistant license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by any licensing board or other entity? | YES | NO |
| 2. | Have you ever had an application to practice as a physician assistant denied or refused by another medical licensing board or other entity? | YES | NO |
| 3. | Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way? | YES | NO |
| 4. | Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration? | YES | NO |
| 5. | Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action? | YES | NO |
| 6. | Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? | YES | NO |
| 7. | Have you ever had a malpractice lawsuit, judgment filed against you or settled a medical malpractice claim? If yes, how many? _____
(Complete a Malpractice Information Claim Form for each claim) | YES | NO |
| 8. | Are you currently being treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant? | YES | NO |
| 9. | Do you currently have any mental illness (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) or any physical illness or condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant? | YES | NO |
| 10. | Within the past two (2) years, has your ability to practice medicine been impaired by any physical or mental illness or by the use of alcohol and/or drugs? | YES | NO |
| 11. | Have you ever discontinued the practicing as a physician assistant for any reason for three consecutive months or more? | YES | NO |
| 12. | Was your medical education / residency training interrupted other than for vacation periods or military service? | YES | NO |
| 13. | Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity? | YES | NO |
| 14. | Have you ever been convicted, pled guilty or pled nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? | YES | NO |

Name: _____

VI. LETTERS OF RECOMMENDATION

Please supply below names and addresses of three licensed physicians or two licensed physicians and a licensed physician assistant willing to write letters of recommendation to support your application for South Carolina medical licensure. **You must request that each physician listed below write directly to the Board** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina. The letters must be signed by the physician writing on your behalf. Make note of the reference number and physician's name listed for when you check your application status later.

Reference 1.

Name: _____

Phone: _____

Address: _____
Street, City, State, Zip

Reference 2.

Name: _____

Phone: _____

Address: _____
Street, City, State, Zip

Reference 3.

Name: _____

Phone: _____

Address: _____
Street, City, State, Zip

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. 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 the application 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.

VII. 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 practice as a physician's assistant 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 as a physician's assistant 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

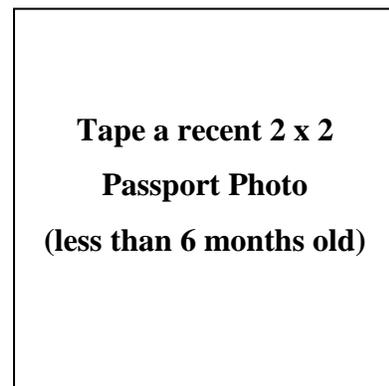
Subscribed and sworn to before me this _____ day
of _____ 20_____.

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)



Notification of Initial Employment

Scope of Practice Guidelines: The guidelines must be practice specific and clearly specify in detail those tasks for which approval is being sought. Board approved scope of practices may be found at: <http://www.llronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM>

Attach with this form the following (These forms are found on the above listed website):

- Cover Sheet for Scope of Practice
- Supervision Statement initialed by PA
- Copy of applicable scope of practice

PHYSICIAN ASSISTANT:

Last Name: _____ Suffix: _____ First: _____ Middle: _____

PRIMARY PHYSICIAN INFORMATION:

Title: M.D. D.O. SC License Number: _____

Last Name: _____ Suffix: _____ First: _____ Middle: _____

Business Name: _____ Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Fax: _____ Email Address: _____

SPECIALTY INFORMATION:

List any certification by ABMS/AOA approved specialty board(s): _____

LOCATION INFORMATION:

List name and location of any hospital or other offices (other than your own) where you request this Physician assistant to assist you:

Hospital/Office	Location:
_____	_____
_____	_____
_____	_____

SCOPE OF PRACTICE:

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervisory physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. The guidelines shall include at a minimum the:

- name, license number, and practice addresses of all supervising physicians;
- name and practice address of the physician assistant;
- date the guidelines were developed and dates they were reviewed and amended;
- medical conditions for which therapies may be initiated, continued, or modified;
- treatments that may be initiated, continued and modified;
- drug therapy, if any, that may be prescribed within the usual scope of the supervising physician's practice; and
- situations that require direct evaluation by or immediate referral to the physician, including Schedule II controlled substance prescription authorization as provided for in Section 40-47-965.

Please note:

Section 40-47-955(D)(E): A supervising physician may not supervise more than three (3) full-time equivalent physician assistants.

The supervising physician has the option to remove an existing physician assistant or submit a letter to the Board indicating that no more than three (3) full-time equivalent physician assistants will work together at any given time.

If the primary supervising physician leaves the practice, the PA must stop working until he/she has written approval from the Board for another physician to serve as his/her supervising physician. An alternate supervising physician may not assume this role without approval from the Board.

CERTIFYING STATEMENT

I hereby certify that the foregoing is correct and true, and I assume responsibility for supervising all tasks performed by my physician assistant under my supervision. It is my responsibility to inform all approved alternate supervising physicians of the responsibilities of supervising my physician assistant.

_____ Primary Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Printed Name	_____ Date

(Attach an additional sheet, if needed.)



CERTIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Proof of successful completion of an educational program for physician assistants that has been approved by the Commission on Accredited Allied Health Programs or its successor organization is required for licensure. Please have this form completed by the school or have an official transcript sent. Transcript must reflect the conferred date of the degree.

Applicant's Information:

Last: _____ Suffix: _____ First: _____ Middle: _____

Student ID: _____ Contact Number: _____

I am applying for a license to practice medicine in the State of South Carolina. Please complete this form and send the original document bearing the institution's official seal to the above listed address.

 Applicant's Signature

 Date

The Medical School is requested to complete this insert and include the school seal along with the Dean's, Registrar's or President's signature.

It is hereby certified that (student name) _____

of (hometown, state or country) _____ attended (full name of school):

_____ from (dates of attendance): _____ to _____

and received a diploma conferring the degree of: _____

and said diploma bears the following date: _____.

(Seal)

 Signature of Dean, Registrar or PA Program Director

 Title

 Date



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: _____



South Carolina Department of Labor, Licensing and Regulation
State Board of Medical Examiners for South Carolina
 P.O. Box 11289 • Columbia, SC 29211
 Phone: 803-896-4500 Fax: 803-896-4515
www.llronline.com/POL/Medical



PHYSICIAN ASSISTANT VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever have been licensed to practice as a physician assistant. You may want to contact each state to see if a fee is required.

In applying for a license to practice as a physician assistant in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature: _____

Name: _____

Address: _____

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____ Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Is license current Yes No If no, why not? _____

Has license been suspended, revoked, or restricted? Yes No If yes, why? _____

Comments, if any: _____

Date: _____

Signature: _____

Print name: _____

Board Seal

Title: _____

Board: _____