



SUMMARY OF REQUIREMENTS FOR A LIMITED LICENSE

Limited licenses may be issued for postgraduate medical residency or fellowship training, as approved by the board. A limited license entitles the licensee to apply for individual controlled substance registration through the Department of Health and Environmental Control. Each limited license is valid for one year or part of one year. Renewal may be considered upon approval of the board. To obtain a limited license in this State, an applicant shall comply with the following requirements as outlined in Section 40-47-31 of the Medical Practice Act:

- A. Applicants for a limited license for medical residency training who are graduates of an approved medical school located in the United States or Canada must complete and submit an application and the appropriate application fee. A completed application must include the following:
- a copy of a contract in which the applicant has been offered a position in a medical residency training program accredited by the American Council for Graduate Medical Education or American Osteopathic Association or a fellowship or a letter from the institution stating the applicant has been recommended for a medical residency training program or a fellowship. The recommendation letter must be addressed and mailed directly to the board office from the institution;
 - a certification of medical education form approved by the board to be completed by the dean, the president, or the registrar of the applicant's medical school or as approved by the board;
 - a supervising physician form approved by the board to be completed by the chairman or residency director of the training program;
 - letters of recommendation from licensed physicians recommending the applicant for a limited license in this State; and
 - verification of licensure in other states, if applicable.
- B. An applicant for a limited license for medical residency training whom is a graduate of a medical school located outside the United States or Canada may be considered on an individual basis. Such applicants shall complete and submit an application and the appropriate application fee. In addition to all other requirements, a completed application must include a copy of a current or permanent Educational Commission for Foreign Medical Graduates (ECFMG) certificate or documentation of successful completion of a Fifth Pathway program, or both. The board may waive this requirement if the applicant has a full-time academic faculty appointment at the rank of assistant professor or greater in a medical school in this State accredited by the American Council for Graduate Medical Education or the American Osteopathic Association. This requirement also may be waived if the applicant:
- has been licensed for five years or more without significant disciplinary action; and
 - holds current certification by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association or another organization approved by the board.
- C. The board may not issue a limited or temporary license to a licensed physician of another state of the United States:
- whose license is currently revoked, suspended, restricted in any way, or on probationary status in that state; or
 - who currently has disciplinary action pending in any state.

- D. A physician in a medical residency training program in this State may apply for a permanent license at least ninety days before his or her limited license expires. No part of a limited license application may be applied to an application for a permanent license. Each application must be filed separately.
- E. For the **United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination, or the Medical Council of Canada Qualifying Examination**, the applicant shall pass all steps within ten years of passing the first taken step. The results of the first three takings of each step examination must be considered by the board. The board may consider the results from a fourth taking of any step; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant's additional medical education or training, the applicant's score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of any step, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.
- F. **LETTERS OF RECOMMENDATIONS**
List the names and address on the application of three physicians willing to write letters of recommendations to support your application to the Board. You must request that each physician write directly to the Board on letterhead indicating that you are known to them, in what capacity and how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina.
- G. **LICENSE VERIFICATION**
Licensure verification is required from each state board by which you are now or have ever been licensed to practice medicine. This verification should be sent directly to the South Carolina Board of Medical Examiners.
- H. **CERTIFICATION OF MEDICAL OR OSTEOPATHIC EDUCATION**
Must be completed and submitted by the applicant's medical school. The applicant must send this document to his/her medical school. The school will complete the form and send it directly back to the Board.
- I. **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. Applicants who possess permanent, temporary or limited licenses may apply for a controlled substance registration.

ADDITIONAL INFORMATION

Include with application:

- **Fee** - Non-refundable application fee for a one fiscal year Limited License is \$150.00. A six-month Limited License (July-December or January-June) is \$75.00. Application will not be processed without the required application fee. Make check payable to **LLR-Board of Medical Examiners**.
- 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)
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change
- Three Letters of Recommendation

Have sent directly to the Board on your behalf:

- Certification of medical or osteopathic education form
- Supervising Physician Form
- License Verification
- A copy of a training contract from your South Carolina program or a letter signed by your Program Director with specific dates of training.

Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Application will be processed within 15 business days of the received date and you will be notified of any deficiencies in your file.

Your application is not considered complete or a limited license issued until all of the required documents have been received. It is a violation of state law if a physician practices medicine before being issued a license. Violators are subject to fines and possible criminal prosecution.

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

You may check the status of your application online by visiting the Board's website at www.lironline.com/pol/medical and select **Application Status**.



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/



Application for a Limited License to Practice Medicine

Include with your application:

- Check or money order made payable to LLR-Board of Medical Examiners (Select one)
 \$150 for one year license; or
 \$75 for six month license
 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.
- 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)
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s), if applicable
- Legal documentation for name change
- Supervisor Form
- ECFMG Certificate, if applicable
- Training Contract from South Carolina program

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

- License Verification from each state medical board that you are currently or have ever been licensed in.
- 3 Letters of Recommendation
- Certification of Medical or Osteopathic Education or Federation Credentials Verification Service (FCVS) – Primary Source Verification

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

I. APPLICANT INFORMATION:

Title: M.D. D.O.

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)

V. 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.

VI. MEDICAL SPECIALTY AND SC LOCATION INFORMATION

1. What is your current medical specialty? _____

2. **Proposed SC Location Information:** _____

Below information is required for Post-Graduate Training:

Name of Hospital/Clinic: _____

Complete Address: _____

Training Program: _____

Entering (1st, 2nd, etc.) _____ year of training in (specialty) _____.

Department Chairman or Training Director: _____

3. **Are you Board certified/recertified by the** (If yes, attach a copy of the certificate):

If yes, date you were certified/recertified: _____

American Board of Medical Specialties (ABMS)

American Osteopathic Association (AOA)

VII. 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

VIII. PERSONAL HISTORY INFORMATION

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

- | | | | |
|-----|--|-----|----|
| 1. | Has your medical license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a medical licensing board or other entity? | YES | NO |
| 2. | Have you ever had an application to practice medicine 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? | 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 of practice? | 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 practice of medicine 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: _____

IX. LETTERS OF RECOMMENDATION

Please supply below names and addresses of three physicians 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.

X. 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 medicine 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 medicine 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)



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
South Carolina Board of Medical Examiners
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www.llronline.com/POL/Medical/



CERTIFICATION OF MEDICAL OR OSTEOPATHIC EDUCATION

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 President

 Title

 Date



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

110 Centerview Dr • Columbia • SC • 29210

P.O. Box 11289 • Columbia • SC • 29211

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

www.llronline.com/POL/Medical/



Supervising Physician Form

Limited License Applicant: _____

Training Hospital: _____ Training Program: _____

To the Department Chairman or Training Director:

The individual physician named above has applied for a Limited License for postgraduate training. As the Department Chairman or Training Director, you are this applicant's supervising physician. As such, you have certain responsibilities to the Board. This document will summarize the current law and your legal responsibilities as the supervising physician.

1. A physician in a residency training program must possess a valid license before beginning to practice. It is a violation of state law if a physician practices in a training program before being issued a license.
2. This applicant has applied for a Limited License. Limited Licenses are valid only for the fiscal year (July 1 – June 30) or part thereof, and must be renewed. It is a violation of state law for a physician to practice on an expired Limited License.
3. If a resident engages in practice without a valid, active license, the Department Chairman, Training Director and any other supervising physicians are subject to discipline under the Medical Practice Act for assisting an unlicensed person to practice medicine. (Section 40-47-110 {B}{12})
4. There are several specific restrictions on a Limited License. A Limited License is restricted to practicing only within the residency training program. Moonlighting on a Limited License is strictly forbidden and a violation of state law. A Limited License is issued for a specific training program and is not transferable to another training program or department.

ATTESTATION:

- I acknowledge and understand my responsibilities as a supervisor of the individual applicant named above.
- I understand that any physician practicing medicine in a residency training program must possess an active, valid license in South Carolina. If a resident engages in unlicensed practice, I as a supervising physician am subject to discipline under the Medical Practice Act.
- I further agree that if the applicant is subject to adverse action within our residency training program as a result of unprofessional, unethical or illegal conduct, that I shall report such action in writing to the SC Department of Labor, Licensing and Regulation Board of Medical Examiners.

Signature of Department Chairman or Training Director

Date

Print Name

SC License Number

Title