



S.C. Department of Labor, Licensing and Regulation
Board of Medical Examiners

110 Centerview Drive, Suite 202
Columbia, SC 29210
Post Office Box 11289
Columbia, SC 29211
(803) 896-4500



**APPLICATION FOR A REACTIVATION OF
RESPIRATORY CARE LICENSE**

IMPORTANT: I hereby make application for reactivation of my license to practice as a Respiratory Care Practitioner in the state of South Carolina and submit the following statement of facts with the required supporting documents: *The application form itself is a public document obtainable under the Freedom of Information Act.* The Application fee must accompany the application. **The application fee is non-refundable.**

(Please type or print clearly)

Applicant's Name: _____
Last First Middle

Home Address: _____
City State Zip

Home Phone: () _____

S.C. Respiratory Care License Number: _____

Email Address: _____

S.C. Medical Director: _____

Place of Employment in South Carolina: _____

_____ Street

_____ City State Zip

Business Phones () _____

*The 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 medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Date Bank (NPDB), among other things.
(Revised 11/15/12)

CONTROL # _____
CHECK # _____
AMOUNT \$ _____

I. PERSONAL DATA

Answer Yes or No

1. Has your Respiratory Care certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? _____
2. Have you ever had an application to practice as a Respiratory Care Practitioner denied or refused by another licensing board or entity? _____
3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? _____
4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? _____
5. Are you currently under any investigation or the subject of pending disciplinary action by any medical licensing board or other entity? _____
6. Is your Respiratory Care Practitioner's certificate/license currently restricted in any way by any medical licensing board, health care facility or other entity? _____
7. Currently or within the last ten years, have you been 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 Respiratory Care Practitioner? _____
8. Has your ability to practice as a Respiratory Care Practitioner ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____
9. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? _____
10. Have you ever discontinued practicing as a Respiratory Care Practitioner for any reason for one month or more? _____
11. Have you ever been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state or local law? (other than a minor traffic violation)? _____
12. Have you ever been known by any other name or surname? _____
13. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license? _____
14. Have you ever been discharged involuntarily from employment? If so, give full details. _____

NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.

POLICY OF THE BOARD REQUIRES INDIVIDUALS WHO HAVE NOT ACTIVELY PRACTICED RESPIRATORY CARE FOR FIVE (5) YEARS OR MORE TO TAKE AND PASS THE NBRC-ENTRY LEVEL EXAMINATION. PROOF OF PASSAGE MUST BE PROVIDED TO THE BOARD BEFORE YOUR LICENSE WILL BE REACTIVATED.

II. PROFESSIONAL INFORMATION

1. Do you plan to care for cardio-pulmonary patients in a home care setting? _____
If yes, you must attach a statement signed by your physician sponsor detailing the duties that you will perform and type of supervision you will receive in performing these duties.

2. Since your Respiratory Care Practitioner's license was placed on inactive status, list all employment activities in chronological order. Please include your place(s) of employment, date(s) of employment, job title and job duties:

Place(s) of Employment	Dates of Employment	Job Title & Job Duties

(Attach additional sheet if needed)

List all states in which you have ever been licensed or certified to practice as a Respiratory Care Practitioner. All State licenses/certificates must be verified directly from each state board. (form enclosed)

State	License/Certificate Number	Date Issued	Basis of Licensure/Certification	Status Active/Inactive

III. REPORT OF CONTINUING EDUCATION

In order to reactivate your Respiratory Care License, you must provide documentation of at least thirty (30) hours of continuing medical education. Proof of attendance must be provided in the form of certificate, diploma or printout. These hours must be obtained within the last 2 years of this application.

Dates Attended	Sponsoring Agency	Name of Topic	Contact Hours

(Attach additional sheet if needed)

TOTAL CONTINUING MEDICAL EDUCATION HOURS

_____ (30 HOURS OF CME REQUIRED)

III. REPORT OF CONTINUING EDUCATION
(continued)

APPROVED CONTINUING EDUCATION PROGRAMS

All programs sponsored or approved by one of the following organizations or their sponsors may be used to meet the continuing education requirement of the South Carolina Respiratory Care Practice Act.

- . American Association for Respiratory Care, or its sponsoring organizations:
 - American Thoracic Society
 - American College of Chest Physicians
 - American Society of Anesthesiologists
- . American Heart Association
- . The Society for Critical Care Medicine
- . The American Lung Association
- . The South Carolina Society for Respiratory Care
- . Allied Health Education Centers of the South Carolina Consortium of Community Teaching Hospitals

Accredited institutional continuing education programs will be accepted with certificate of attendance that specifies total number of contact hours. These continuing education programs must have been accredited by groups such as the Accreditation Council for Continuing Medical Education or the American Nurses Credentialing Center's Commission on Accreditation.

If the program is not approved by one of the above organizations, approval must be sought from the Respiratory Care Committee of the South Carolina Department of Labor, Licensing and Regulation. This approval must be sought 30 days prior to the program. Programs not having prior approval will be subject to review and may be denied. Approval must be applied for on forms provided by the Board. Content for these programs must be relevant to the professional growth and development of the Respiratory Care Practitioner.

Academic courses **may not** be used to meet the continuing education requirement of the South Carolina Respiratory Care Practice Act. **Medical directors no longer have signature approval authority.** If your continuing medical education credits are audited, you must show proof of attendance at the programs that are sponsored or approved by one of the above organizations. Proof of attendance must be provided in the form of a certificate, diploma or printout. Please direct any questions regarding the need for approval of continuing education programs to the Board office.

IV. AFFIDAVIT

I, _____, being duly sworn, depose and say that I am the person described and identified, that I am of good moral character 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 respiratory care in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (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 physical qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative, 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 to the Board in connection with this application.

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 act shall constitute the cause for denial or revocation of my license to practice in South Carolina.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary 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 and to federal and state entities, as required by law.

Applicant's Signature _____ Date _____

Sworn to me and subscribed before me this _____

day of _____, 20 _____

_____(L.S.) _____

Signature of Notary Public _____ for

My Commission Expires: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this Affidavit of Eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

- 1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or
- 2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
 - a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
 - b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.
- 3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
 - a. ___ I am a US citizen, not physically present or employed in the United States.
 - b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check the acceptable secure and verifiable document(s) you hold. A copy of the verifiable document(s) must be attached to the Affidavit of Eligibility.

- A valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card. Number _____; Date of Expiration: _____
- A valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit. State: _____; Number _____; Date of Expiration: _____.
- Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.
- Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____
- Certificate of Naturalization with intact photo.
- Certificate of (US) Citizenship with intact photo.
- Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where the secure and verifiable document(s) was issued.

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____
(Include a copy of the card with the Affidavit)

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and 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

Date

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The 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.

06/28/12 Affidavit of Eligibility

10/05/12 Revised

Respiratory Care Verification of Licensure/Certification

Complete top portion and forward a copy to each State Medical Board where you have ever held approval to perform/practice as a Respiratory Care Practitioner. You may want to contact each state to see if a fee is required.

CLEARANCE FROM OTHER STATE BOARDS

In applying for a license to practice as a Respiratory Care Practitioner in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or ever held a license/certificate. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding myself directly to:

SC Dept. of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive,
Post Office Box 11289
Columbia, South Carolina 29211
(803) 896-4500

PLEASE TYPE OR PRINT

Signature _____
Name _____
Address _____

City State Zip

DO NOT DETACH

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

Full Name of Licensee: _____
State of: _____ License/Certificate No.: _____
Date Issued: _____ Date Expires: _____
License/Certificate is current? _____ If no, why not? _____
Has license been suspended, revoked or restricted? _____ If yes, why? _____
Has licensee ever been required to appear before your Board? _____ If yes, why? _____

Derogatory information, if any Comments: _____

(Board Seal)

Signature: _____
Title: _____
State Board of: _____
Date: _____

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(803) 896-4515 Fax

REQUIREMENTS FOR REACTIVATION OF RESPIRATORY CARE LICENSE

READ REQUIREMENTS CAREFULLY BEFORE COMPLETING APPLICATION.

I. REQUIREMENTS FOR REACTIVATION

In order to reactivate your South Carolina respiratory care practitioner license, the applicant must file a written application on forms provided by the Board and:

- (a) answer all questions on the application fully;
- (b) have all state licenses/certificates verified (active and inactive);
- (c) submit application fee of \$160;
- (d) provide 30 hours of CME obtained within the last 2 years of this application and;
- (e) provide a statement to the Board regarding your activity since your license was placed on inactive status by the Board. This statement must include all places of employment, job titles and job duties.
- (f) Criminal Background Check (instructions included)

II. FEES (Application fee is non-refundable)

The biennial reactivation fee is \$160.

III. APPLICATION FORM

The reactivation application form is self-explanatory. It sets forth the required supporting documents and/or information that must be submitted with your reactivation application. The Board **will not** consider an applicant for reactivation until a complete application along with the appropriate fee is submitted.

An application will be considered incomplete until all of the information listed in Section 1 is submitted:

IV. PROCESSING TIME

Applications having all information with no identifiable problems will be expeditiously processed. Incomplete applications or problematic applications will require additional processing time.

V. NAME CHANGE

If your name has changed since you last registered with this Board, you must provide a copy of the legal document (marriage license, divorce decree, etc.) before your name can be changed with this Board.

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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 • Fax: 803-896-4515 • www.llronline.com/POL/Medical

Criminal Background Check (CBC)

Effective May 1, 2008, an applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in 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).

The cost of conducting a criminal history background check is \$55.00. Make checks payable to Morphotrust USA.

To schedule an appointment online with Morphotrust USA, please visit www.identogo.com or call 1-866-254-2366 for assistance in scheduling your CBC.

South Carolina applicants will need to show one (1) form of identification - South Carolina State Issued Photo Drivers License.

For out of state applicants who do not hold a South Carolina State Issued Photo Drivers license, you will need to submit two (2) forms of identification from the list below:

State issued photo Drivers License

Social Security Card

Passport

Birth Certificate

Marriage License

If you are a non-resident of South Carolina and reside in an area where no Morphotrust USA fingerprinting centers are available, please follow the Non-Resident Card Scan Processing Procedures on the next page. Click here or visit webpage www.identogo.com to see if your state has Morphotrust USA fingerprinting centers.

Do not return fingerprint card or fingerprint processing fee to the Board.

ORI # SC920110Z



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Non-Resident Card Scan Processing Procedures

Applicants who reside in an area where no Morphotrust USA fingerprinting centers are available may use Morphotrust USA Card Scan Processing Program. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. Converting a “hard card” into an electronic record enables an applicant to have their fingerprint record processed as quickly as if they had traveled to an electronic fingerprint processing location. The section below details the procedures for submitting fingerprints to the Card Scan Processing Unit.

South Carolina Licensing and Certification

-
- 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.
 - FBI applicant cards are available from the state agency requiring you to be fingerprinted (i.e. Department of Education, Insurance, Labor, Licensing, and Regulation, etc.). Please contact those licensing and certifying agencies directly to obtain fingerprint cards. *Due to agency specific information, Morphotrust USA does not provide fingerprint cards to applicants.*
 - Applicants need to make sure the fingerprint cards are completely filled out. Required information includes: ORI number, full name, social security number, date of birth, home address, sex, height, weight, hair color, eye color, place of birth (state or country only), citizenship, and reason fingerprinted.
 - The ORI number and Reason Fingerprinted that must be used for on the fingerprint card should be provided by the licensing or certifying agency. **ORI # SC920110Z**
 - **Failure to completely fill out the information on the fingerprint card will result in the card being returned to the applicant, which will delay the licensing process.**
 - The fully completed card, along with the appropriate fee (indicated in the application packet) should then be mailed to the following address:

*Morphotrust USA
Attn: SC Card Scan Department
3051 Hollis Drive Suite 310
Springfield, IL 62704*

Please include a daytime telephone number where the applicant can be reached in case there are questions about the fingerprint card.

- Please include the full name of the applicant on each check or money order.
- **Do not send completed certification or licensing applications to Morphotrust USA;** these documents should be returned to the state agency that will be issuing the license.
- Applicants wishing to verify that a fingerprint card has been processed may call 866-254-2366 and speak with a customer service representative.

Morphotrust USA
3051 Hollis Drive, Springfield, IL 62704
Telephone 866-254-2366 Facsimile 800-272-2080 www.identogo.com