South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
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P.O. Box 11289 • Columbia • SC• 29211
Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515
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ADDITIONAL SKILLS REQUEST FORM

Please complete application in its entirety including additional information or clarification to consider the approval of the skill. The committee member shall provide in a timely manner, and upon receipt, a decision will be made within ten business days (§40-47-938).

REQUESTING SUPERVISING PHYSICIAN INFORMATION:

Primary Supervising Physician Name:_________________________________ License No.: _______________

Direct Number: ___________________________ Email: ____

Physician Assistant Name: ____ License No.: _______________

ADDITIONAL SKILLS REQUEST:

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Include with this request supporting documentation of the competence of the physician assistant to perform the requested additional medical acts, tasks, or functions. This may include documented training under the direct supervision of the physician, education, or certification of proposed practices or other educational methods.

Sample Format – Competency for Modified Scope Request (Optional)

Observed 5 times	Dosing	Outcome	Complication
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Assist 5 times	**Dosing**	**Outcome**	**Complication**
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Perform 5 times	**Dosing**	**Outcome**	**Complication**
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			
Patient Chart Number and Date			

EXAMPLE

As the supervising physician, I am satisfied that the physician assistant listed above is competent to perform the medical act, task or function being requested.

Primary Supervising Physician Signature: _________________________________ Date: ____________________

Physician Assistant Signature: ____ Date: _____________________