South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Dentistry
110 Centerview Dr • Columbia, SC 29210
P.O. Box 11329 • Columbia, SC 29211-1329
Phone: 803-896-4599 • Contact.dentistry@llr.sc.gov • Fax: 803-896-4719
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TEMPORARY LIMITED AUTHORITY FOR RETIRED, INACTIVE OR LAPSED DENTISTS TO ADMINISTER COVID-19 VACCINES

This application is to be completed by a retired, inactive, or lapsed dentist who was in good standing at the time they last held an active license and has been inactive no more than five (5) years. This is for dentists who are interested in assisting with the administration of the COVID-19 vaccine during the pendency of the COVID-19 public health emergency and as authorized pursuant to the Joint Order of the South Carolina Department of Health and Environmental Control (DHEC) and the Board of Dentistry issued on January 28, 2021.

Email the completed application to: Contact.Dentistry@llr.sc.gov

An email will be sent to the Applicant verifying that the Board granted the temporary limited authority to administer the COVID-19 vaccine. The limited authority will be valid for the pendency of the COVID-19 public health emergency unless amended or altered by order of DHEC or the South Carolina Board of Dentistry.

Date: ___________________________

Applicant Name: ____

Address: ______________________________________ City:______________________ State:________ Zip: _________

Phone:__________________________ Email: ____

*Social Security #:________________________ Birthdate: __________________ Sex: Female Male

LICENSURE INFORMATION:

Last State of Licensure:___________________ License No.________________ Expiration Date: __________________

Employer/Agency/Facility (If known at this time): ____

Contact Person:____ Phone: _________________________________

Email: ____

I HEREBY AFFIRM that at the time I ceased being licensed with a state Board of Dentistry, my license was in good standing. I further affirm that I have read the DHEC-BOD Order regarding the temporary authorization to administer COVID-19 vaccines and understand the limitations on this temporary authorization. I understand that I must also complete the COVID-19 training programs available through the Centers for Disease Control and Prevention prior to administering the vaccine, as outlined in the Joint DHEC-Board of Dentistry Order. I understand that this authorization to administer COVID-19 vaccines does not allow me to practice dentistry.

Applicant signature:____ Date: _____________________________

*** The disclosure of the social security number for identification purposes is authorized and mandated by state and federal statutes. The social security number is not subject to disclosure as public information.**