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
llr.sc.gov/med

APPLICATION TO PRACTICE MEDICINE

Documentation required for your application:

- Check or money order in the amount of $500 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.
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your Social Security card
- A 2"x2" passport-type photo
- Notarized Verification of Lawful Presence Form
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s) or letter from the certifying board, if applicable
- **Verification of Legal Name:** A license must be issued in the applicant's legal name as verified by a vital statistics birth certificate (not hospital birth certificate), valid driver's license, passport or other legal document acceptable to the board. Examples of acceptable legal name change documents include a marriage certificate, divorce decree or court order approving legal name change.

Documentation to submit to the Board's Office from the issuing agent via email: Medboard@llr.sc.gov or mail:

- Federation Credentials Verification Service (FCVS) – Primary Source Verification
- License Verification from each state medical board that you are currently or have ever been licensed in (active and non-active licenses).
- Criminal Background Check (CBC) – Board will forward instructions once application is received.
- American Medical/Osteopathic Association Physician Profile (AMA or AOA)

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

APPLICANT INFORMATION

Title: ☐ M.D. ☐ D.O.

Last Name:______________________ First:______________________ Middle:_________________ Suffix:____

Have you ever legally changed your name? ☐ Yes ☐ No Prior 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(es): ____

Business Name: ____ Phone: __________________________

Date of Birth: _____________________ Social Security Number: ______________________________________

Place of Birth (City, State or Country): ____

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

Intent to practice in South Carolina: Please write a brief statement of the reason you wish to practice in South Carolina.

PROFESSIONAL EDUCATION INFORMATION
List in chronological order from date of 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)	Graduation/Program Completed?	Degree Earned

1. Are you a graduate from a medical school located outside of the United States or Canada? ☐ Yes ☐ No
   a) **If yes,** ECFMG Certificate Number: ______________________
      i. Is this a permanent certificate? ☐ Yes ☐ No

INTERNSHIP AND RESIDENCY TRAINING INFORMATION
Complete the requested information below on all training programs completed in the US or Canada. Failure to disclose any training program information may result in the denial of your application or other appropriate action. Attach an additional sheet if necessary.

School Name	Location (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Did you complete program?

RECORD OF LICENSURE
If you currently hold or have previously held a license, certification or registration for any medical profession, please list details below. You will need to contact each state board and have an official license verification sent directly to the Board via email: Medboard@llr.sc.gov or mail. If you hold or have held licenses in additional states, please list them on the State License Verification Form including the license type, state name, license number.

State/ Jurisdiction	License/ Certification/ Registration Number	Type of License/ Certification/ Registration		State/ Jurisdiction	License/ Certification/ Registration Number	Type of License/ Certification/ Registration

MEDICAL SPECIALTY AND SOUTH CAROLINA LOCATION INFORMATION

1. What is your current medical specialty? ______________________________

2. **Proposed South Carolina Location Information** (If known)**:**

   Name of Hospital/Clinic: ______________________________

   Complete Address: ______________________________

3. **Are you Board certified/recertified by the:** ☐Yes ☐ No
   ☐ American Board of Medical Specialties (ABMS)
   ☐ American Osteopathic Association (AOA)

   If yes, date you were certified/recertification: ____________________
   (If yes, attach a copy of the certificate)**:**

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 MM/YY	To MM/YY	Employer Name	Office Address	Type of Practice

PERSONAL HISTORY INFORMATION

If you answer yes to any of the questions below, you must attach an Explanation of "Yes" Answer Form. Additional information/documentation may be required.

1. Have you ever discontinued the practice of medicine for any reason for four consecutive months or more? ☐Yes ☐ No

2. Have you been arrested, charged, convicted of, or pled guilty or nolo contendere to, a criminal offense of any kind, whether or not a sentence was imposed or suspended, except a minor traffic offense? (A DUI or similar alcohol-related driving offense is not a minor traffic offense and must be reported.) ☐Yes ☐ No

   If yes, include official court documentation along with the disposition and the Explanation of "Yes" Answer Form.

3. Do you have any physical or mental disease or condition, including an addiction to drugs or alcohol, that currently interferes with your ability to competently and safely perform the essential functions of practice? (If you are voluntarily enrolled in the Recovering Professionals Program (RPP) and have remained in full compliance, you may answer 'No' with respect to any condition involving abuse of alcohol or drugs. If you have a physical or mental disease or condition that is appropriately being treated and does not currently impair your judgment or otherwise adversely affect your ability to practice, you may answer 'No.') ☐Yes ☐ No

4. Have you ever had a malpractice lawsuit filed against you, a judgment returned/filed against you, or settled a medical malpractice claim? ☐ Yes ☐ No
If yes, how many? ___________

If yes, complete a Malpractice Information Claim Form for each claim, and include official court documentation along with the disposition with the Explanation of Yes Answer Form.

5. Has any licensing agency revoked, suspended, restricted, sanctioned, fined, reprimanded, or otherwise disciplined any occupational or professional license, certificate, or registration you have held? ☐ Yes ☐ No

If yes, provide an official copy of the board order and any supporting documentation with the Explanation of "Yes" Answer Form.

6. Have you ever had an application to practice medicine denied or refused by another medical licensing board or other entity? ☐ Yes ☐ No

7. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, federal or state agency, health care facility, professional organization or other entity? ☐ Yes ☐ No

8. Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration? ☐ Yes ☐ No

9. Have you ever voluntarily surrendered hospital privileges or had any hospital privileges denied, revoked, suspended or restricted in any way? ☐ Yes ☐ No

10. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action? ☐ Yes ☐ No

11. 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

12. Was your medical education / residency training interrupted other than for vacation periods or military service? ☐ Yes ☐ No

SAFEGUARDING PATIENT MEDICAL RECORDS

Pursuant to S.C. Reg. § 81-1(A), each physician licensee actively practicing within the State of South Carolina **must** designate a partner, personal representative, or other responsible party to assume responsibility for patient medical records in the case of incapacity, death or disappearance of the licensee, including any circumstances whereby the licensee is unable for any reason to provide continuity of care, appropriate referral or patient medical records upon a valid request of the patient. If your practice is owned by a health care system, specifically identify the health care system.

This section is required if you are treating South Carolina residents. Naming yourself as the designated party is not acceptable.

Contact Information for Designated Responsible Party

Name: ____ Phone No.: ______________________

Address: ____
(Street/PO Box, City, State, Zip Code)

CERTIFYING STATEMENT

I, ____, affirm that I am the person described and identified, and the person named in all 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, 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 understand that I may be contacted by the Board and asked to sign a release for records should my application reveal additional information is necessary to approve my application.

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 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.

I affirm that 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 to the best of my knowledge. I understand that I am declaring under penalty of perjury under the laws of South Carolina that the information provided within this application is true and correct to the best of my knowledge. (S.C. Code 16 9 10(A)(2) "It is unlawful for a person to willfully give false, misleading, or incomplete information on a document, record, report, or form required by the laws of this State.") Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute cause for denial, cancellation, or revocation of my license to practice as a physician in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address, telephone number, and email address.

____

Signature of Applicant

____

Print Name of Applicant

Tape a recent 2 x 2

Passport Photo

(less than 6 months old)

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.