



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](mailto:Medboard@llr.sc.gov) • Fax: 803-896-4515  
[llr.sc.gov/med](http://llr.sc.gov/med)

## **APPLICATION FOR LICENSURE AS AN ARTICULAR DETOXIFICATION THERAPIST REQUIREMENTS AND INSTRUCTIONS**

To obtain an auricular detoxification therapist license in this State, an applicant shall comply with the following requirements as outlined in [S.C. Code § 40-47-735](#) of the Medical Practice Act.

### **TRAINING/ CERTIFICATIONS**

Applicants must submit proof of successful completion of a nationally recognized training program in auricular detoxification therapy for the treatment of chemical dependency detoxification and substance abuse. Applicants must also submit a certificate documenting successful completion of a nationally recognized clean needle technique course.

### **SUPERVISION**

Auricular therapy takes place under the direct supervision of a licensed acupuncturist or a person licensed to practice medicine. Applicants must submit an original signed [Supervisor Form](#) with your application.

### **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.

### **OUT-OF-STATE LICENSE VERIFICATION**

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](mailto:Medboard@llr.sc.gov) or mail.

### **INTERVIEW AND TEMPORARY LICENSE**

When your application is completed, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license.

### **ADDITIONAL INFORMATION**

Treatment by an auricular detoxification therapist is strictly limited to the five ear-point treatment protocol for detoxification, substance abuse, or chemical dependency as stipulated by the National Acupuncture Detoxification Association (NADA).

Note: Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period, you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, examination scores, etc.



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## APPLICATION FOR LICENSURE AS AN AURICULAR THERAPIST

### Documentation to include with your application:

- \$100 fee made payable to the SC Board of Medical Examiners. Cash is not accepted. 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
- [Notarized Verification of Lawful Presence Form](#)
- 2 x 2 passport type photo
- [Supervising Physician or Acupuncturist Form](#), completed
- **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 submitted directly to the Board's office address above from the issuing agent via email: [Medboard@llr.sc.gov](mailto:Medboard@llr.sc.gov) or mail by license type:

- License verification from each state medical board by which you are currently or have even been licensed
- Copy of your certificate in auricular detoxification therapy for the treatment of chemical dependency and substance abuse (NADA)
- Copy of your certificate documenting successful completion of a nationally recognized clean needle technique course

### APPLICANT INFORMATION

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: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(If different than above)

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**For Statistical Purposes Only:** Race: \_\_\_\_\_ Gender: ☐ Female ☐ Male

### SUPERVISOR INFORMATION

Provide the name and license number of your supervising physician/acupuncturist. Complete and attach the [Supervising Physician or Acupuncturist Form](#).

Supervising Physician/Acupuncturist: \_\_\_\_\_ License Number: \_\_\_\_\_

**NATIONAL CERTIFICATION BOARD FOR ACUPUNCTURE AND HERBAL MEDICINE  
(NCBAHM), *Formerly NCCAAOM***

NCBAHM Certification Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**PROFESSIONAL EDUCATION INFORMATION**

List in chronological order from date of graduation all professional education. Attach additional sheet(s) if needed.

| Institution/Program | Location<br>(City and State or<br>Country) | Graduation/Program<br>Completed? | Degree<br>Earned |
|---------------------|--------------------------------------------|----------------------------------|------------------|
|                     |                                            |                                  |                  |
|                     |                                            |                                  |                  |
|                     |                                            |                                  |                  |

**LICENSE VERIFICATION**

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](mailto: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.

1. Have you held or do you currently hold a license, certification or registration in another state for a medical profession? ☐ Yes ☐ No

If yes, indicate the state(s) and status of licensure below.

Type of License: \_\_\_\_\_ State: \_\_\_\_\_ License number: \_\_\_\_\_

Type of License: \_\_\_\_\_ State: \_\_\_\_\_ License number: \_\_\_\_\_

Type of License: \_\_\_\_\_ State: \_\_\_\_\_ License number: \_\_\_\_\_

**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<br>(Month / Year) | To<br>(Month / Year) | Employer<br>Name | Office Address | Type of Practice |
|------------------------|----------------------|------------------|----------------|------------------|
|                        |                      |                  |                |                  |
|                        |                      |                  |                |                  |
|                        |                      |                  |                |                  |
|                        |                      |                  |                |                  |

## PERSONAL HISTORY QUESTIONS

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 discontinued the practice of acupuncture for any reason for four (4) 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 an official statewide criminal background check from the state in which the conviction occurred and 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 lawsuit filed against you, judgment obtained against you, or settled a claim arising out of your work as an acupuncturist? ☐ Yes ☐ No

If yes, how many? \_\_\_\_\_

If yes, include official court documentation along with the disposition and 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 had an application to practice as an acupuncturist denied or refused by another medical/acupuncture 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 association or other entity? ☐ Yes ☐ No
8. Have you voluntarily surrendered any license related to your practice as an acupuncturist? ☐ Yes ☐ No

## ATTESTATION

I, \_\_\_\_\_ (print name), 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 an acupuncturist 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

\_\_\_\_\_  
Date

*Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period, you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, license verifications, etc.*

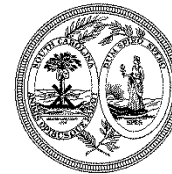
## PRIVACY DISCLOSURE

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.



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)



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**SUPERVISING PHYSICIAN OR ACUPUNCTURIST FORM**

**I will be supervising:**

Therapist Name: \_\_\_\_\_

**Type:** ☐ Auricular Therapist ☐ Auricular Detoxification Therapist

**Supervising Physician or Acupuncturist Information:**

Name: \_\_\_\_\_ SC License Number: \_\_\_\_\_

Address/Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

1. List and attach copies of all acupuncture training.

| School | Course | Date Completed |
|--------|--------|----------------|
| _____  | _____  | _____          |
| _____  | _____  | _____          |

2. Describe below the nature of the working relationship for the auricular therapist or auricular detoxification therapist. (Attach additional pages if necessary)

3. Describe below the types of conditions for which acupuncture will take place. (Attach additional pages if necessary)

- I acknowledge and agree, if approved by the Board, that I shall be responsible for supervising the auricular therapist or directly supervising the auricular detoxification therapist named in this application. I further acknowledge that as the supervising physician or acupuncturist, I will be available to attend to any unexpected, adverse effects.
- I agree that should I become aware of any unethical, unprofessional or illegal acts or omissions on the part of the auricular therapist or auricular detoxification therapist, I shall immediately report such conduct in writing to the State Board of Medical Examiners of South Carolina.
- I have carefully read the above questions and answered them completely and I declare that all statements made by me herein and materials supplied herewith are true and correct. Further, if approved as the supervising physician or acupuncturist of this auricular therapist or auricular detoxification therapist, **I agree to keep the Board informed of any future changes in my address or working relationship with this auricular therapist or auricular detoxification therapist.**

\_\_\_\_\_  
Supervising Physician or Acupuncturist Signature

\_\_\_\_\_  
Date