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

SUMMARY OF REQUIREMENTS FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT – ELECTRONIC APP

The Forms contained in this packet may not be mailed in with payment and processed as a regular application. They may only be used with the online electronic application where payment is remitted electronically.

You must follow these instructions to obtain a permanent license to practice as a physician assistant in SC. An applicant shall comply with the following requirements as outlined in Section 40-47-945 of the Physician Assistant Practice Act.

ONLINE ELECTRONIC APPLICATION PROCESS

If you are a new user, create a user account and log into: https://eservice.llr.sc.gov/NewAppsV3/

To submit a completed application you will need to pay the **$120** non-refundable application fee. (DO NOT MAIL A CHECK IN WITH DOCUMENTS.)
You will have the opportunity to upload your required documentation at the end of the online application. This includes:

- Notarized Signature Affidavit with a 2"x2" professional photo (Passport Photo)
- Legal documentation for name change, if applicable
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your social security card
- Copy of your current NCCPA Certificate: Visit www.nccpa.net to obtain "verify certificate" page.
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable

Have submitted directly to the Board office address above from the issuing agent:

- Certification of Education Form or Official Transcripts
- License Verification from each state medical board that you are currently or have ever been licensed in.
- Criminal Background Check (CBC): Board will forward instructions once application is received.

LICENSURE REQUIREMENTS

Section 40-47-945 (A) Except as otherwise provided in this article, an individual shall obtain a permanent license from the board before the individual may practice as a physician assistant. The board shall grant a permanent license as a physician assistant to an applicant who has:

(1) submitted a completed application on forms provided by the Board;
(2) paid the non-refundable application fee;
(3) successful completion of an educational program for physician assistants approved by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor organization;
(4) successful completion of the NCCPA certifying examination and provide documentation that he or she possesses a current, active, NCCPA Certificate;
(5) certified that the applicant is mentally and physically able to engage safely in practice as a physician assistant;

(6) no licensure, certificate, or registration as a physician assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant's practice as a physician assistant;

(7) good moral character;

(8) submitted to the Board any other information the Board considers necessary to evaluate the applicant's qualifications;

EDUCATION

Applicant will need to have the Certification of Physician Assistant Education sent in or an official transcript with the conferred date reflected on it.

NCCPA CERTIFICATE

Applicant must provide a copy of their current/active NCCPA Certificate. Visit www.nccpa.net to obtain "verify certificate" page. Proof of current NCCPA Certificate must contain the expiration date.

VERIFICATION OF OUT OF STATE LICENSURE

A license verification from every state an applicant is currently or has previously been licensed is required to be sent in directly from the licensing state board. A License Verification Form is provided as a courtesy; however the SC Medical Board will accept an official state license verification form from the issuing state board.

CRIMINAL BACKGROUND CHECK (CBC)

An applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in Section 40-47-36 of the Medical Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received.

Allow 15 business days for processing before contacting the board regarding the status of your application.

You may check the status of your application by visiting the website at www.llr.sc.gov/med

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

NOTARIZED SIGNATURE AFFIDAVIT

Certifying Statement:

I, ____ being duly sworn, depose and say that I am the person described and identified, 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 as a physician assistant in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, 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 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 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 an act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

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.

____
Signature of Applicant

____
Print Name of Applicant

Subscribed and sworn to before me this ______ day

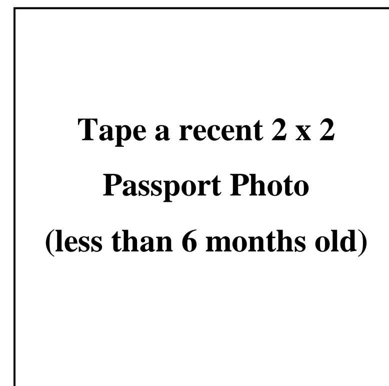
of _______________20________.

Notary Signature: ______________________________

Print Name: __________________________________

Notary for the State of: _________________________

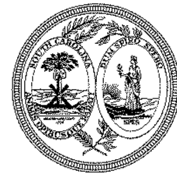
My Commission expires: ________________________



(Notary Seal)

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)

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

CERTIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Proof of successful completion of an educational program for physician assistants that has been approved by the Commission on Accredited Allied Health Programs or its successor organization is required for licensure. Please have this form completed by the school or have an official transcript sent. Transcript must reflect the conferred date of the degree.

Applicant's Information:

Last: ____________________ Suffix: _____ First: ___________________ Middle: _________________

Student ID: ____________________ Contact Number: ______________________

I am applying for a PA license in the State of South Carolina. Please complete this form and send the original document bearing the institution's official seal to the above listed address.

____
Applicant's Signature

____
Date

Please complete this form and include the school seal along with the Dean's, Registrar's, President's or PA Program Director's signature.

It is hereby certified that (student name) ____

of (hometown, state or country) _______________________________________ attended (full name of school):

____________________________________ from (dates of attendance): _____________ to ____________

and received a diploma conferring the degree of: ____

and said diploma bears the following date: ____________________ .

(Seal)

____
Signature of Dean, Registrar or PA Program Director

____
Title

____
Date

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

VERIFICATION OF LICENSURE FORM

Use this form only if it is required by another state.

Complete the top portion of this form and forward a copy to each state board by which you are now or ever have been licensed to practice medicine. You may want to contact each state to see if a fee is required.

Applicant's Signature: ______________________________

Print Name: ______________________________

Address: ______________________________

FOR STATE BOARD TO COMPLETE

This section to be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners. You may send a state issued license verification in lieu of this form.

Full name of licensee: ______________________________

Graduate of: ______________________________ Date of Degree: ______________

State of: __________ License No.: ____________________ Date Issued: ______________

Is license current? ☐ Yes ☐ No If no, why not? ______________________________

Has license been suspended, revoked, or restricted? ☐ Yes ☐ No If yes, why? ____________________

____

Comments, if any: ______________________________

____

Date: ____________________ Signature: ____________________

Print Name: ____________________

Board Seal Title: ____________________

Board: ____________________

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

MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

______________________________ ______________________
Physician Name Office Telephone No.

____
Address City State Zip

MALPRACTICE COMPLAINT:
Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.

Patient's Name: (Not required) ______________________________

Age: _________ Sex: _________ Date of Occurrence: ______________________

Place of Occurrence: ______________________________

Indicate your position in case: (i.e., resident, primary physician, etc.) ______________________

FILED AGAINST: ☐ Individual Doctor ☐ Group ☐ Hospital

List names of other defendant-doctors and/or hospitals:

____

____

____

DISPOSITION: ☐ Pending ☐ Jury Verdict ☐ Settled ☐ Dismissed ☐ Dropped

If there has been a verdict or settlement, please provide the following information:

Legal Outcome: ______________________________

Total Amount Paid: (If any) ______________________ Date Paid: ______________________

Amount attributable to you: ______________________________

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Signature: ______________________________ Date: ______________________