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

MD OR DO LIMITED LICENSE APPLICATION REQUIREMENTS (6 MONTHS OR 1 YEAR)

Limited licenses may be issued for postgraduate medical residency or fellowship training, as approved by the South Carolina Board of Medical Examiners (Board). A limited license entitles the licensee to apply for individual controlled substance registration through the Department of Public Health. Each limited license is valid for one year or part of one year. Renewal may be considered upon approval of the Board.

To obtain a limited license in this State, an applicant shall comply with the following requirements as outlined in S.C. Code Section 40-47-31

TRAINING CONTRACT

Applicants must provide a copy of a contract in which the applicant has been offered a position in a medical residency training program accredited by the American Council for Graduate Medical Education or American Osteopathic Association or a fellowship or a letter from the institution stating the applicant has been recommended for a medical residency training program or a fellowship. The recommendation letter must be addressed and mailed directly to the Board office from the institution.

SUPERVISING PHYSICIAN FORM

A supervising physician form approved by the Board to be completed by the chairman or residency director of the training program is required for licensure. The supervising physician form can be sent to via email at medboard@llr.sc.gov or by mail.

CERTIFICATION OF MEDICAL EDUCATION/TRANSCRIPT

Applicants must provide a Certification of Medical Education form approved by the Board to be completed by the dean, the president, or the registrar of the applicant's medical school or as approved by the Board or copy of an official transcript sent directly to the board by the education institution. Certification form and transcript can be sent to via email at medboard@llr.sc.gov or by mail.

LETTERS OF RECOMMENDATION

Three letters of recommendation from licensed physicians recommending the applicant for a limited license in this State are required for licensure. The letters can be sent to via email at medboard@llr.sc.gov or by mail.

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 or mail.

FOREIGN MEDICAL GRADUATES

An applicant for a limited license for medical residency training who is a graduate of a medical school located outside the United States or Canada may be considered on an individual basis. Such applicants shall complete and submit an application and the appropriate application fee. In addition to all other requirements, a completed application must include a copy of a current or permanent Educational Commission for Foreign Medical Graduates (ECFMG) certificate or documentation of successful completion of a Fifth Pathway program, or both. The Board may waive this requirement if the applicant has a full-time academic faculty appointment at the rank of assistant professor or greater in a medical school in this State accredited by the American Council for Graduate Medical Education or the American Osteopathic Association. This requirement also may be waived if the applicant:

- has been licensed for five years or more without significant disciplinary action; and
- holds current certification by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association or another organization approved by the Board.

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.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS
Applicants applying for a limited physician license with the SC Board of Medical Examiners will be subject to a state and national fingerprint criminal background check. The fingerprint criminal background checks are required pursuant to § 40-47-36 of the South Carolina Code of Laws.

Instructions for the fingerprint process will be sent to the applicant after their application for licensure is received by the South Carolina Board of Medical Examiners. DO NOT have your fingerprints or CBC report processed until you have applied and received instructions from the board. **Submittal of the fingerprints prior to application will cause an automatic rejection of the criminal background check and fingerprints will need to be submitted again to complete the application.**

LIMITED LICENSURE LIMITATIONS
The Board may not issue a limited or temporary license to a licensed physician of another state of the United States:

- whose license is currently revoked, suspended, restricted in any way, or on probationary status in that state; or
- who currently has disciplinary action pending in any state.

PERMANENT LICENSURE
A physician in a medical residency training program in this State may apply for a permanent license at least ninety days before his or her limited license expires. No part of a limited license application may be applied to an application for a permanent license. Each application must be filed separately.

CONTROLLED SUBSTANCE REGISTRATION
Applications for both federal and state registration are available from the Drug Control Division, South Carolina Department of Public Health, applicants who possess permanent, temporary or limited licenses may apply for a controlled substance registration.

ADDITIONAL INFORMATION
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, license verifications, etc.

Your application is not considered complete or a limited license issued until all of the required documents have been received. It is a violation of state law if a physician practices medicine before being issued a license. Violators are subject to fines and possible criminal prosecution.

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APPLICATION FOR A LIMITED LICENSE TO PRACTICE MEDICINE

Documentation required for your application:

- Check or money order 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.

  Select one:

  ☐ $130 for one-year license; or

  ☐ $75 for six month license

- 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
- A 2"x2" passport-type photo
- Training contract from South Carolina program (or recommendation letter* see below)
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s), 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 submitted directly to the Board office address above from the issuing agent:

- License Verification from each state medical board that you are currently or have ever been licensed in.
- Supervising Physician Form
- Three letters of recommendation
- Certification of Medical or Osteopathic Education Form
- * Letter stating that the applicant has been recommended for residency training program of fellowship
- Criminal Background Check (CBC) – Board will forward instructions once application is received.

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): _____

Date of Birth: _____ Social Security Number: _____

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

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

INTERNSHIP AND RESIDENCY TRAINING INFORMATION
Proposed South Carolina Internship/Residency/ Fellowship Training Location Information

Name of Hospital/Clinic: _____

Complete Address: _____

Training Program: _____

Entering (1st, 2nd, etc.) _____ year of training in (specialty) _____

Department Chair or Training Director: _____

Previous Internship/Residency and 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?

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

RECORD OF EXAMINATION

List below information for all examinations taken in the United States (National Boards, FLEX, USMLE, COMLEX, etc.). Include all examination attempts. Do not include ABMS/AOA board certification. Attach additional sheet(s) if needed.

Name of Examination	Location (State or Country)	Date of Exam (Month / Year)	Passed/Failed Score

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 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 INFORMATION

1. What is your current medical specialty? _____

2. **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

LETTERS OF RECOMMENDATION

Please supply below names and addresses of three physicians willing to write letters of recommendation to support your application for South Carolina medical licensure. You must request that each physician listed below write directly to the Board indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina. The letters must be signed by the physician writing on your behalf. Make note of the reference number and physician's name listed for when you check your application status later.

Reference 1:

Name: _____ Phone: _____

Address: _____

Street, City, State, Zip

Reference 2:

Name: _____ Phone: _____

Address: _____

Street, City, State, Zip

Reference 3:

Name: _____ Phone: _____

Address: _____

Street, City, State, Zip

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

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 limited 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