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

# LIMITED LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT REQUIREMENTS AND INSTRUCTIONS – 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.**

**Include with your application:**

- Submit payment in the amount of **$25** via credit card or electronic check. (DO NOT MAIL A CHECK IN WITH DOCUMENTS.)
  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.
- Upload a copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Upload a copy of your Social Security card
- Upload a Notarized Signature Affidavit with a 2"x2" professional photo (Passport Photo)
- Upload Limited PA Supervisor Agreement
- Upload Malpractice Claim Information Form, if applicable
- Upload 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.
- **Current letter of eligibility from the NCCPA regarding your eligibility to sit for the next available NCCPA examination (www.nccpa.net)**

An applicant for limited licensure in South Carolina must comply with Section 40-47-950.

(A) The Board may issue a limited physician assistant license to an applicant who has:

(1) submitted a completed application on forms provided by the Board;
(2) paid the non-refundable application fee;
(3) successfully completed an educational program for physician assistants approved by the American Medical Association Counsel on Medical Education;
(4) never previously failed two consecutive NCCPA certifying examinations and has registered for, or intends to register to take the next offering of, the NCCPA examinations; (Insert 2)
(5) certified that he or she is mentally a 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;
(9) Criminal Background Check: Board will forward instructions once application is received.

(B) A limited license is not renewable and is valid only until the results of a limited licensee's two consecutive NCCPA certifying examinations are reported to the board. When a limited licensee has failed two consecutive NCCPA certifying examinations, or fails one exam and does not take the NCCPA certifying examination at the next opportunity or, after applying for a limited license, fails to register for the next offering of the examination, the limited license is immediately void and the applicant is no longer eligible to apply for further limited licensure. (Insert 2)

(C) A licensee who supervises another practitioner shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of their respective profession or shall hold an active unrestricted academic license to practice medicine in this State. The supervising physician of a limited licensee must be physically present on the premises at all times when the limited licensee is performing any task. No on-the-job training, or task not listed on the application, may be approved for a limited license holder.

(D) Upon successful passage of the NCCPA examination, you may update to a permanent license by submitting a copy of your NCCPA certificate and an update fee of $120.

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: _____

Rev: 02-02-2015

## 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

# 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

# SUPERVISORY AGREEMENT

**Primary Supervising Physician Name**:_____ License No.: _____

**Physician Assistant Name:** _____ License No.: _____

## PRIMARY SUPERVISING PHYSICIAN ATTESTATION

I hereby agree to become the primary supervising physician for the above named physician assistant.

I understand as a supervising physician I must not practice in a situation in which the number of NPs, CNMs, or CNSs providing clinical services with whom I am working, combined with the number of PAs providing clinical services whom I am supervising, is greater than six individuals at any one time, provided, however, that the board may approve an exception to these requirements upon application by me, if the board determines that an exception is warranted and that quality of care and patient safety will be maintained.

I understand as the supervising physician that I bear the ultimate professional and legal responsibility for the practice and conduct of the physician assistant.

I understand I must notify the SC Medical Board, in writing, if this supervisory relationship changes.

I understand I must practice, above all, in accordance with the South Carolina Medical Practice Act and Regulations of the South Carolina Medical Board and other federal and state laws.

_____ _____
Signature of Primary Supervising Physician Date

## PHYSICIAN ASSISTANT ATTESTATION

I understand I may only perform a medical act, task or function that is listed and approved on the scope of practice guidelines.

If a supervisory relationship is terminated, a current alternate supervising physician for the PA may serve as a supervising physician under the existing scope of practice guidelines for a period not to exceed 90 days until a new supervising physician is designated and new scope of practice guidelines are approved.

I understand I must notify the SC Medical Board, in writing, if this supervisory relationship changes.

I understand I must practice, above all, in accordance with the South Carolina Medical Practice Act and Regulations of the South Carolina Medical Board and other federal and state laws.

_____ _____
Signature of Physician Assistant 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

# 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: _____