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 AND FORMS (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 Health and Environmental Control. 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 Section 40-47-31 of the Medical Practice Act:

A. Applicants for a limited license for medical residency training who are graduates of an approved medical school located in the United States or Canada must complete and submit an application and the appropriate application fee. A completed application must include the following:

- 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;
- 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;
- a supervising physician form approved by the Board to be completed by the chairman or residency director of the training program;
- letters of recommendation from licensed physicians recommending the applicant for a limited license in this State; and
- verification of licensure in other states, if applicable.

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

B. 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.

C. 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.

D. 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.

APPLICATION INSTRUCTIONS – Forms in **bold type** are provided below.

Upload the following with your online application and fee ($150 for one year or $75 for six months):

- Copy of your valid driver's license, state-issued ID, passport or military ID
- Copy of your Social Security card
- A 2"x2" professional photo (passport photo)
- **Notarized Verification of Lawful Presence in the United States Affidavit of Eligibility**
- **Notarized Signature Affidavit**
- **Malpractice Claim Information** form, if applicable
- Copy of ABMS and/or AOA Certificate(s), if applicable
- ECFMG Certificate, if applicable
- Contract for residency training program or fellowship (or recommendation letter*, see below)
- Legal documentation of name change (marriage cert., divorce decree, court order, etc.), if applicable

Have sent directly to the Board on your behalf from issuing agent:

- License verification from each state board by which you are now or have ever been licensed to practice medicine. We provide a **Verification of Licensure** form as a courtesy but will accept a state board-issued form.
- **Supervising Physician Form**
- Letters of recommendation from three physicians 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.
- **Certification of Medical or Osteopathic Education –** The applicant must send this form to his/her medical school. The school will complete the form and send it directly to the Board.
- *Recommendation letter for residency training program or fellowship. A copy of the residency or fellowship contract is also acceptable.

CONTROLLED SUBSTANCE REGISTRATION

Applications for both federal and state registration are available from the Narcotic and Drug Control Division, Dept. of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, (803) 896-0634. Applicants who possess permanent, temporary or limited licenses may apply for a controlled substance registration.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS

Pursuant to Section 40-47-36 of the Medical Practice Act, an applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check.

The Board will send you instructions on how to have your fingerprints processed once your application is received. DO NOT have your fingerprints or CBC report processed until you have submitted an application and received instructions directly from the Board.

CBC reports received that do not have an application on file with the Board may be purged after a period of time and the fingerprint process would need to be repeated.

ADDITIONAL INFORMATION

Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. After initial processing, the Board will notify you of any deficiencies in your application.

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.

You may check the status of your application online by visiting the Board's website at www.llr.sc.gov/med/ and select **Application Status.**

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NOTARIZED SIGNATURE AFFIDAVIT

Certification:

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 medicine 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

Tape a recent 2 x 2
Passport Photo
(less than 6 months old)

Subscribed and sworn to before me this _____ day

of _____20_____.

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____ (Notary Seal)

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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: _____

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)

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Supervising Physician Form

Limited License Applicant: _____

Training Hospital: _____ Training Program: _____

To the Department Chairman or Training Director:

The individual physician named above has applied for a Limited License for postgraduate training. As the Department Chairman or Training Director, you are this applicant's supervising physician. As such, you have certain responsibilities to the Board. This document will summarize the current law and your legal responsibilities as the supervising physician.

1. A physician in a residency training program must possess a valid license before beginning to practice. It is a violation of state law if a physician practices in a training program before being issued a license.

2. This applicant has applied for a Limited License. Limited Licenses are valid only for the fiscal year (July 1 – June 30) or part thereof, and must be renewed. It is a violation of state law for a physician to practice on an expired Limited License.

3. If a resident engages in practice without a valid, active license, the Department Chairman, Training Director and any other supervising physicians are subject to discipline under the Medical Practice Act for assisting an unlicensed person to practice medicine. (Section 40-47-110 {B}{12})

4. There are several specific restrictions on a Limited License. A Limited License is restricted to practicing only within the residency training program. Moonlighting on a Limited License is strictly forbidden and a violation of state law. A Limited License is issued for a specific training program and is not transferable to another training program or department.

ATTESTATION:

- I acknowledge and agree, if approved by the Board, as a licensee who supervises another practitioner I shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of my respective profession or that I shall hold an active unrestricted academic license to practice medicine in this State. S.C. Code Ann. Sec. 40-47-195 (A).

- I understand that any physician practicing medicine in a residency training program must possess an active, valid license in South Carolina. If a resident engages in unlicensed practice, I as a supervising physician am subject to discipline under the Medical Practice Act.

- I further agree that if the applicant is subject to adverse action within our residency training program as a result of unprofessional, unethical or illegal conduct, that I shall report such action in writing to the SC Department of Labor, Licensing and Regulation Board of Medical Examiners.

_____ _____
Signature of Department Chairman or Training Director Date

_____ _____
Print Name SC License Number

_____
Title

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CERTIFICATION OF MEDICAL OR OSTEOPATHIC EDUCATION

Applicant's Information:

Last: _____ Suffix: _____ First: _____ Middle: _____

Student ID: _____ Contact Number: _____

I am applying for a license to practice medicine 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

The Medical School is requested to complete this insert and include the school seal along with the Dean's, Registrar's or President'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 President

_____
Title

_____
Date

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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: _____