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 AND INSTRUCTIONS FOR A LICENSE TO PRACTICE MEDICINE

To obtain a permanent license to practice medicine in this State, an applicant shall comply with the following requirements as outlined in S.C. Code §40-47-32. Please visit the Board's website at https://llr.sc.gov/med/, select **Laws/Policies** to review the South Carolina Medical Practice Act.

EDUCATION REQUIREMENTS

Applicant must meet one of the following:

a. Graduated from a medical school located in the United States (US) or Canada that is accredited by the Liaison Committee on Medical Education or other accrediting body approved by the board; or

b. Graduated from a school of osteopathic medicine located in the US or Canada accredited by the Commission on Osteopathic College Accreditation or other accrediting body approved by the board; or

c. Graduated from a medical school located outside the United States or Canada, must possess a permanent Standard Certificate from the Education Commission on Foreign Medical Graduates (ECFMG).
   - Notwithstanding the provisions of this subsection, the board may waive the ECFMG or Fifth Pathway requirement if the applicant is to have a full-time academic faculty appointment at the rank of assistant professor or greater at a medical school in this State.

Note: Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA) are approved accrediting bodies.

POSTGRADUATE TRAINING REQUIREMENTS

Applicants must meet one of the following requirements:

a. Graduates of approved medical or osteopathic schools located in the US or Canada shall document the successful completion of a minimum of one year of postgraduate medical residency training approved by the board; or

b. Graduates of medical schools located outside the United States or Canada shall document a minimum of three years of progressive postgraduate medical residency training in the United States approved by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons.

   - An applicant has been licensed in another state for five (5) years or more, without significant disciplinary action, will only be required to document one year of postgraduate residency training approved by the board;

   - Foreign graduates may satisfy the three-year postgraduate training requirement with at least one year of approved training in combination with certification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

   - The board may accept a full-time academic appointment at the rank of assistant professor or greater in a medical or osteopathic school in the United States as a substitute for, and instead of, postgraduate medical residency training. Each year of this academic appointment may be credited as one year of postgraduate medical residency training for purposes of the board's postgraduate training requirements.

- Graduates who have completed at least two and one-half years of progressive postgraduate medical residency training in the program in which they are currently enrolled may be issued a license upon certification from the program of their good standing and expected satisfactory completion.

c. Document successful completion of a Fifth Pathway Program; and
   - Complete a minimum of three (3) years progressive postgraduate medical residency training in the US that has been approved by the ACGME or AOA or post graduate training in Canada that has been approved by the Royal College of Physicians and Surgeons; or

   - Be board eligible or board certified by a specialty board recognized by the American Board of Medical Specialties (ABMS), the AOA, or another organization approved by the board;

EXAMINATION REQUIREMENTS

- An applicant shall document to the satisfaction of the board successful completion of exams required by Medical Practice Act, S.C. Code § 40-47-32 (C) and (F).

For the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination, or the Medical Council of Canada Qualifying Examination, the applicant shall pass all steps within ten years of passing the first taken step. The results of the first three takings of each step examination must be considered by the board. The board may consider the results from a fourth taking of any step; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant's additional medical education or training, the applicant's score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of any step, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

Note: The Board recognizes ABMS and AOA as organizations that certify specialty boards.

CURRENT COMPETENCY OR OTHER QUALIFICATIONS

In addition to meeting all other licensure requirements, an applicant shall pass the Special Purpose Examination (SPEX) or the Composite Osteopathic Variable-Purpose Examination (COMVEX), unless the applicant can document **within ten** years of the date of filing a completed application to the board one of the following:

(1) National Board of Medical Examiners examination;
(2) National Board of Osteopathic Medical Examiners examination;
(3) FLEX;
(4) USMLE;
(5) MCCQE;
(6) SPEX;
(7) COMVEX;
(8) COMLEX-USA;
(9) ECFMG;
(10) Certification, recertification, or a certificate of added qualification examination by a specialty board recognized by either the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or other organization approved by the board; or

(11) one hundred fifty hours of Category I continuing medical education in the three years preceding the date of the application by an applicant who is currently certified by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or other organization approved by the board, which certification is not time limited and does not require recertification by examination. Such Category I continuing medical education must be approved by the American Medical Association or American Osteopathic Association, or other national organization approved by the board, as appropriate. Seventy-five percent of these hours must be related to the applicant's area of specialty. This is the only exception to the ten year requirement of this subsection that does not require an examination or reexamination.

WAIVERS

Note: The additional examination required pursuant to subsection 40-47-32 (E) must be waived if the applicant is to practice in a position within the South Carolina Department of Corrections, South Carolina Department of Health and Environmental Control, South Carolina Department of Mental Health, the South Carolina Department of Disabilities and Special Needs, or the Disability Determination Services Unit of the State Agency of Vocational Rehabilitation. *A license issued pursuant to this waiver is immediately invalid if the individual leaves that position or acts outside the scope of employment within the department*. A change in agency may be approved upon presentation to the board of a copy of a contract in which the individual has been offered a position within the South Carolina Department of Corrections, the South Carolina Department of Public Health (formerly, the Department of Health and Environmental Control), the South Carolina Department of Mental Health, or the South Carolina Department of Disabilities and Special Needs, or the Disability Determination Services Unit of the State Agency of Vocational Rehabilitation.

A waiver of the SPEX Exam requirement can be requested under 40-47-32 (E). To apply for a waiver, contact the board via email at medboard@llr.sc.gov.

PRIMARY SOURCE VERIFICATION

American Medical/Osteopathic Association Physician Profile – An AMA or AOA physician profile must be received by the board. Please visit the AMA online at https://commerce.ama-assn.org/amaprofiles/ or the AOA online at www.aoaprofiles.org to request a profile be sent to the LLR-Board of Medical Examiners. You do not need to be a member to have the physician profile sent to the board.

Federation Credentials Verification Services Profile - Primary source verification of an applicant's identity, medical education, postgraduate training, examination history, disciplinary history, and other core information required for licensure in this State must be provided through an independent credentials verification organization approved by the board. Contact the Federation Credentials Verification Services (FCVS) at 400 Fuller Wiser Rd Suite 300, Euless TX, 76039, telephone (888) 275-3287 or email fcvs@fsmb.org to request your Physician Information Profile. Please visit the Federation of State Medical Boards online at https://www.fsmb.org/fcvs/ for more information on FCVS profiles. If the FCVS profile does not contain all transcripts, copies of transcripts must be submitted to the Board from the educational institution.

VERIFICATION OF LEGAL NAME

A license must be issued in the applicant's legal name as verified by a birth certificate or other legal document acceptable to the board. Examples of acceptable documents include a valid passport, driver's license, vital statistics birth certificate (not hospital birth certificate), marriage certificate, divorce decree or court order approving legal name change.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS

Applicants applying for a 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.**

LICENSE VERIFICATION

If you currently hold or have previously held a license, certification or registration for any medical profession, 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.

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.

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APPLICATION TO PRACTICE MEDICINE

Documentation required for your application:

- Check or money order in the amount of $500 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.
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your Social Security card
- A 2"x2" passport-type photo
- Notarized Verification of Lawful Presence Form
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s) or letter from the certifying board, 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 to submit to the Board's Office from the issuing agent via email: Medboard@llr.sc.gov or mail:

- Federation Credentials Verification Service (FCVS) – Primary Source Verification
- License Verification from each state medical board that you are currently or have ever been licensed in (active and non-active licenses).
- Criminal Background Check (CBC) – Board will forward instructions once application is received.
- American Medical/Osteopathic Association Physician Profile (AMA or AOA)

Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

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): _____

Business Name: _____ Phone: _____

Date of Birth: _____ Social Security Number: _____

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

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

Intent to practice in South Carolina: Please write a brief statement of the reason you wish to practice in South Carolina.

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

INTERNSHIP AND RESIDENCY 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?

RECORD OF LICENSURE

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 AND SOUTH CAROLINA LOCATION INFORMATION

1. What is your current medical specialty? _____

2. **Proposed South Carolina Location Information** (If known)**:**

   Name of Hospital/Clinic: _____

   Complete Address: _____

3. **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

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

SAFEGUARDING PATIENT MEDICAL RECORDS

Pursuant to S.C. Reg. § 81-1(A), each physician licensee actively practicing within the State of South Carolina **must** designate a partner, personal representative, or other responsible party to assume responsibility for patient medical records in the case of incapacity, death or disappearance of the licensee, including any circumstances whereby the licensee is unable for any reason to provide continuity of care, appropriate referral or patient medical records upon a valid request of the patient. If your practice is owned by a health care system, specifically identify the health care system.

This section is required if you are treating South Carolina residents. Naming yourself as the designated party is not acceptable.

Contact Information for Designated Responsible Party

Name: _____ Phone No.: _____

Address: _____
(Street/PO Box, City, State, Zip Code)

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 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
(less than 6 months old)

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: _____

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)