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

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

Documentation required for your application:

- Check or money order in the amount of $110 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
- Malpractice Claim Information Form, if applicable
- Copy of current NCCPA Certificate
- **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's office address above from the issuing agent:

- Certification of Education Form or official transcripts with conferred date directly from the educational institution.
- License verification from each state professional board by which you are currently or have even been licensed, registered, permitted or certified (active and non-active licenses).
- Criminal Background Check (CBC) – Board will forward instructions once application is received.

APPLICANT INFORMATION

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:_____

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)

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

NCCPA Certificate Number: _____ Expiration Date: _____

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 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 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/YR	TO MM/YR	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.')

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?

   If yes, provide an official copy of the board order and any supporting documentation with the Explanation of "Yes" Answer Form.

   ☐ Yes ☐ No

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, _____ (print name), 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 assistant 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 Type
(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.