South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
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Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515
llr.sc.gov/med

2025-2027 LATE RENEWAL APPLICATION FOR PHYSICIANS

Renewal Instructions/Requirements:

- Check or money order only (no cash) in the amount of $140 made payable to the S.C. Board of Medical Examiners. (All fees are non-refundable. A returned check fee of up to $30, or an amount specified by law, may be assessed on all returned funds.)
- Practice is not allowed after June 30, 2025. A Practice Activity Statement is incorporated into this renewal form and must be completed and notarized.
- After June 30, 2025, licenses will lapse and be subject to a $100 per month late fee until June 30, 2026.
    - If you practiced after June 30, 2025, include a $1,000 per month penalty fee.
    - There is a fee schedule at the end of this renewal form for your convenience.
- If you practiced after June 30, 2025, include a $1,000 per month penalty fee.
- Submit documentation of 40 continuing medical education (CME) hours dated July 1, 2023 – June 30, 2025 with this renewal application. You must complete all 40 CME hours before submitting your renewal (40 total = 30 specialty, 8 may be non-specialty, 2 must be in prescribing and monitoring of controlled substances).
- Beginning July 1, 2026, a reactivation application is required.
- You must provide current contact information as required by S.C. Code Section 40-47-41(C), which states "[a] licensee shall notify the Board in writing within fifteen business days of any change or residential address, office address, or office telephone number." Failure to provide this information as required could result in disciplinary action against your license.

If you would like your name added to the SC Statewide Emergency Registry of Volunteers, please visit: Better Impact.

SC License No.: _____ Title: ☐ M.D. ☐ D.O.

Note for SC residents: To find your congressional district you may go to: https://www.scstatehouse.gov/legislatorssearch.php

LICENSEE INFORMATION

Last Name:_____ First:_____ Middle:_____

Since you were licensed, have you legally changed your name? ☐ Yes ☐ No Prior Name(s):_____
If yes, please submit legal documentation supporting the change(s). (Marriage certificate, divorce decree, court documents.)

Home Address:_____City:_____State:_____Zip:_____District:_____
Congressional District (SC residents only)

Mailing Address:_____City:_____State:_____Zip:_____
(if different than above)

Phone No.: _____ Fax No.: _____

Email: _____

Are you a resident of SC? ☐ Yes ☐ No
Do you have an active license in another state? ☐ Yes ☐ No
Are you currently in a residency training or fellowship program? ☐ Yes ☐ No

Specify training program: _____

Activity Status (Check one only):

- ☐ Active Practice, in SC
- ☐ Active Practice, Out-of-State: _____
- ☐ Active Practice, Volunteer work only
- ☐ Not Currently Practicing, Disabled
- ☐ Not Currently Practicing, Seeking Licensed Practice
- ☐ Resident-in-Training
- ☐ Not Currently Practicing, Not Seeking Licensed Practice
- ☐ Retired
- ☐ Other: _____

Do you use telemedicine to deliver services to patients located in South Carolina? ☐ Yes ☐ No

PRIMARY EMPLOYMENT INFORMATION

Business Name (Primary Place of Practice): _____

Check here if your position at your primary place of practice is best described as "Hospitalist" ☐

Business Address: _____ City: _____ State: ____ Zip: _____

County: _____ Phone No.: _____ Fax No.: _____

Avg. Hours/week: _____

Primary location practice specialty: _____

Is your Primary Place of Practice owned by a hospital or health system? ☐ Yes ☐ No

Primary Practice Setting (Where patients are seen):

- ☐ 44 Admin/Regulatory Hlth Agency
- ☐ 50 Business Establishment
- ☐ 20 Com Hlth Ctr/Rural Hlth Cln
- ☐ 21 Fed Military Hlth Facility
- ☐ 22 Fed Non-Military Hlth Facility
- ☐ 27 Free-Standing Amb Surg Ctr
- ☐ 13 Free-Standing Clinic
- ☐ 29 Free-Standing ER/Urgent Care
- ☐ 11 Hosp, Non-Fed General
- ☐ 23 Hosp, Non-Fed Psy
- ☐ 24 Hospital, Non-Fed Rehab
- ☐ 14 Outpat Mental Hlth Clinc
- ☐ 15 Private Office
- ☐ 31 Univ/College of Med
- ☐ 71 Other: _____

Form of Practice (Source of Income):

- ☐ 32 County Government
- ☐ 34 Fed Civilian (Incl. USPHS)
- ☐ 35 Fed Military
- ☐ 28 Non-Profit Hlth Agency
- ☐ 25 Other Private Emp
- ☐ 43 Resident/Intern Training
- ☐ 11 Self, Solo
- ☐ 13 Self, Group, Same Specialty
- ☐ 14 Self, Group, Multi-Specialty
- ☐ 33 State Gov
- ☐ 44 Volunteer
- ☐ 42 Other: _____

SECONDARY EMPLOYMENT INFORMATION

Business Name: _____

Business Address: _____ City: _____ State: ____ Zip: _____

County: _____ Phone No.: _____ Fax No.: _____

Avg. Hours/week: _____

Second Practice Setting (Where patients are seen):

- ☐ 44 Admin/Regulatory Hlth Agency
- ☐ 50 Business Establishment
- ☐ 20 Com Hlth Ctr/Rural Hlth Cln
- ☐ 21 Fed Military Hlth Facility
- ☐ 22 Fed Non-Military Hlth Facility
- ☐ 27 Free-Standing Amb Surg Ctr
- ☐ 13 Free-Standing Clinic
- ☐ 29 Free-Standing ER/Urgent Care
- ☐ 11 Hosp, Non-Fed General
- ☐ 23 Hosp, Non-Fed Psy
- ☐ 24 Hospital, Non-Fed Rehab
- ☐ 14 Outpat Mental Hlth Clinc
- ☐ 15 Private Office
- ☐ 31 Univ/College of Med
- ☐ 71 Other

Secondary location practice specialty: _____

TERTIARY EMPLOYMENT INFORMATION

Business Name: _____

Business Address: _____ City: _____ State: ____ Zip: _____

County: _____ Phone No.: _____ Fax No.: _____

Avg. Hours/week: _____

Tertiary Practice Setting (Where patients are seen):

☐ 44 Admin/Regulatory Hlth Agency	☐ 50 Business Establishment	☐ 20 Com Hlth Ctr/Rural Hlth Cln
☐ 21 Fed Military Hlth Facility	☐ 22 Fed Non-Military Hlth Facility	☐ 27 Free-Standing Amb Surg Ctr
☐ 13 Free-Standing Clinic	☐ 29 Free-Standing ER/Urgent Care	☐ 11 Hosp, Non-Fed General
☐ 23 Hosp, Non-Fed Psy	☐ 24 Hospital, Non-Fed Rehab	☐ 14 Outpat Mental Hlth Clinc
☐ 15 Private Office	☐ 31 Univ/College of Med	☐ 71 Other

Tertiary location practice specialty: _____

ALL PRACTICE ACTIVITIES

Hours Per Week: Enter the approx. hours per week spent in practice across all locations

Total Hours: _____

- Patient Care Hours: _____
- Administration Hours: _____
- Teaching Hours: _____
- Research Hours: _____
- Training Hours: _____
- Other Hours: _____

Hours Per Week Spent In Specialties: Should equal to Total Hours listed above (enter the approx. total hours per week in all specialties, across all practice locations)

- Primary Specialty: _____ Hours in Primary Specialty: _____
- Secondary Specialty: _____ Hours in Secondary Specialty: _____
- Tertiary Specialty: _____ Hours in Tertiary Specialty: _____

List all South Carolina hospital affiliations you presently have:

- _____
- _____
- _____

Do you perform office-based surgery as defined in S.C. Code Regs 81-96? ☐ Yes ☐ No

If Yes, you must register with the Board. Please see the regulation for detail.

CONTINUING MEDICAL EDUCATION (CME)

You must complete ALL 40 CME hours before submitting your renewal (40 total = 30 specialty, 8 may be non-specialty, 2 must be in prescribing and monitoring of controlled substances). DO NOT SUBMIT continuing education certificates to the Board. The Board will not maintain copies. A random audit will be conducted at the end of the renewal period, requiring proof of CME documentation. To manage and report CME, licensees may submit their continuing education hours to CE Broker prior to renewing. You may activate your free CE Broker account using the following link: https://cebroker.com/plans

A list of approved controlled substance CME providers is available at https://www.llr.sc.gov/med/.

Is this your first renewal since your initial permanent license? ☐ Yes ☐ No

If yes, you are not required to report continuing education for this renewal.

If this is not your first renewal since applying for permanent licensure, have you documented evidence of continuing education earned since July 1, 2023? ☐ Yes ☐ No

If this is not your first renewal since applying for permanent licensure, have you documented evidence of completion of two (2) Category 1 CME hours (date range for completion 7/1/2023 – 6/30/2025) related to prescribing and monitoring controlled substances? ☐ Yes ☐ No

PERSONAL HISTORY QUESTIONS

If you answer Yes to any of the below questions, please attach a detailed written explanation along with any supporting documentation.

1. Since your last renewal (or if this is your first renewal since your initial license application), has your medical license been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by any medical licensing board or other entity? ☐ Yes ☐ No

2. Since your last renewal (or if this is your first renewal since your initial license application), have you had an application to practice medicine denied or refused by another medical licensing board or other entity? ☐ Yes ☐ No

3. Since your last renewal (or if this is your first renewal since your initial license application), have you voluntarily surrendered or had any hospital privileges denied, revoked, suspended, or restricted in any way? ☐ Yes ☐ No

4. Since your last renewal (or if this is your first renewal since your initial license application), have you voluntarily surrendered or relinquished a medical license, controlled substance registration, or DEA registration? ☐ Yes ☐ No

5. Since your last renewal (or if this is your first renewal since your initial license application), have you had your employment been terminated by an employer for any reason or have you resigned from any hospital, institution, or health care facility in lieu of disciplinary action? ☐ Yes ☐ No

6. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility, or other entity? ☐ Yes ☐ No

7. Since your last renewal (or if this is your first renewal since your initial license application), have you 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? _____
   (Complete a Malpractice Information Claim Form for each claim.)

8. Since your last renewal (or if this is your first renewal since your initial license application), have you experienced 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

9. Since your last renewal (or if this is your first renewal since your initial license application), have you discontinued the practice of medicine for any reason for three consecutive months or more? ☐ Yes ☐ No

10. Since your last renewal (or if this is your first renewal since your initial license application), has your ability to prescribe controlled substances been denied, revoked, suspended, or limited by any hospital, health care facility or other entity? ☐ Yes ☐ No

11. Since your last renewal (or if this is your first renewal since your initial license application), have you been convicted of, or pled guilty or nolo contendere to, a criminal offense of any kind, except a minor traffic offense? (A DUI is not a minor traffic offense and must be reported.) ☐ Yes ☐ No

12. Since your last renewal (or if this is your first renewal since your initial license application), have you changed your specialty? ☐ Yes ☐ No

ELIGIBILITY INFORMATION

The Board is required to verify lawful presence in the United States prior to the issuance of a license and prior to renewal of a license. If your immigration status has changed (including, but not limited to, a change in immigration status type, *i.e.* grant of citizenship or change from a visa holder to an asylee, etc.) **or** if you have immigration documentation on file with the Board that expires during the renewal period and you have not yet submitted updated documentation to the Board, you will need to upload an updated Verification of Lawful Presence form prior to renewal. Please include updated supporting documents with your Verification of Lawful Presence form.

Since your last renewal (or if this is your first renewal since your initial license application), has there been any change in the status of your lawful presence in the United States **or** will your lawful presence documentation on file with the Board expire before June 30, 2027? ☐ Yes ☐ No

If yes, attach an updated Verification of Lawful Presence form, found here.

SAFEGUARDING PATIENT MEDICAL RECORDS

Each physician licensee actively practicing within the State of South Carolina shall 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.

S.C. Code Regs. § 81-1(A).

I affirm that I have read and understand the obligation set forth in the paragraph above and in S.C. Code Regs. § 81-1(A). ☐ Yes ☐ No

ATTESTATION

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina licensure.

Signature: _____ Date: _____

PRIVACY NOTICE

South Carolina law requires the agency to collect personal information which is only disseminated as required by law. 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 your renewal application and other documents on file 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 purposes.

MD/DO Permanent Late Renewal Payment Schedule	
Without Penalty	**Practice Penalty**
$140.00 renewal fee + $100.00 additional late fee per month. All CME must be dated 7/1/2023 – 6/30/2025.	$140.00 renewal fee + $100.00 additional late fee per month + $1,000.00 penalty fee per month for unauthorized practice if you practiced in South Carolina.
July $140+$100 = $240	July $240+$1,000= $1,240
August $140+200= $340	August $340+$2,000= $2,340
September $140+$300= $440	September $440+$3,000= $3,440
October $140+400= $540	October $540+$4,000= $4,540
November $140+500= $640	November $640+$5,000= $5,640
December $140+600= $740	December $740+$6,000= $6,740
January $140+700= $840	January $840+$7,000= $7,840
February $140+800= $940	February $940+$8,000= $8,940
March $140+900= $1040	March $1,040+$9,000= $10,040
April $140+1,000= $1140	April $1,140+$10,000= $11,140
May $140+1,100= $1240	May $1,240+$11,000= $12,240
June $140+1,200= $1340	June $1,340+$12,000= $13,340
July 1, 2026 Submit Reactivation Application	

PRACTICE ACTIVITY STATEMENT MADE PURSUANT TO S.C. CODE SECTION 40-47-43

Licensee Name: _____ License Number: _____

I understand this is a sworn statement made under oath.

I hereby certify that: (Check one)

☐ I **have not** practiced medicine in South Carolina since the lapse of my South Carolina medical license on June 30, 2025.

☐ I **have** practiced medicine in South Carolina since the lapse of my medical license on June 30, 2025.

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina licensure.

Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____ , 20_____ .

Notary Signature: _____

Print Notary Name: _____

Notary Public for the State of: _____

Commission Expiration Date: _____

(Notary Seal)

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