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 AN ACADEMIC LICENSE

To obtain an academic license to use in an educational setting in this State, an applicant shall comply with the following requirements as outlined in Section 40-47-33 of the Medical Practice Act located on the Board's website at https://llr.sc.gov/med/ select **Laws/Policies**.

SECTION 40-47-33. Academic license; qualifications; responsibility of dean for compliance with practice limitations.

(A) The issuance of an academic license is initiated by a written request from the dean of the medical school outlining the candidate's credentials, proposed role at the academic institution, and the reasons for requesting an exception to the usual course of permanent licensure. The candidate shall meet the following requirements:

(1) The individual must have the rank of assistant professor or higher.

(2) The individual must have established academic credentials and a compelling reason to be invited by the dean.

(3) The academic license may be used only in the educational setting or in a training program associated with the medical school.

(4) Use of the academic license is limited to the designated practice site only. It is not for independent practice or "moonlighting" situations.

(B) In that an academic license is issued at the dean's request for his accommodation, the dean is professionally responsible under Section 40-47-110 for the academic licensee's compliance with the limitations of practice under an academic license.

LETTER FROM DEAN

Letter from the Dean outlining proposed role.

LETTERS OF RECOMMENDATIONS

List the names and address on the application of three physicians willing to write letters of recommendations to support your application to the Board. You must request that each physician write directly to the Board on letterhead indicating that you are known to them, in what capacity and how long, and outlining characteristics they believe qualify you for an academic medical licensure in South Carolina.

LICENSE VERIFICATION

Licensure verification is required from each state board by which you are now or have ever been licensed to practice medicine. This verification should be sent directly to the South Carolina Board of Medical Examiners.

PHYSICIAN PROFILE

American Medical/Osteopathic Association Physician Profile – An AMA or AOA physician profile must be received by the board. Please visit the AMA online at http://www.ama-assn.org/amaprofiles or the AOA online at www.aoa-net.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.

EDUCATION

Have an official set of transcripts mailed directly to the Board office.

Foreign Applicant:

- International medical graduates must also submit:

  (1) A copy of your permanent or current ECFMG certificate or (2) document successful completion of a Fifth pathway program, or (3) furnish copies of current ECFMG certificate and documentation of all post-graduate training completed in the United States. All copies must be initialed by the physician in charge of the applicant's program.

- **Federation Credentials Verification Service (FCVS**) - You may utilize the FCVS to have your Credentials verified to this Board. For application and information, contact the FCVS, at 400 Fuller Wiser Road, Suite 300, Euless, TX 76039, at 1-888-275-3287 or via email at fcvs@fsmb.org. Applications for the FCVS may be downloaded from the web at http://www.fsmb.org.

ADDITIONAL INFORMATION

Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Application will be processed within 15 business days of the received date and you will be notified of any deficiencies in your file.

Allow 15 business days for processing before contacting the board regarding the status of your application.

You may check the status of your application online by visiting the Board's website at https://eservice.llr.sc.gov/NewAppsV3 and select **Application Status**.

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APPLICATION FOR ACADEMIC LICENSURE

Include with your application:

- Check or money order (no cash) in the amount of $150 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 or Passport
- Copy of your Social Security card
- A 2"x2" professional photo (Passport Photo)
- Notarized Verification of Lawful Presence
- Malpractice Claim Information form, if applicable
- Copy of ABMS and/or AOA Certificate(s), if applicable
- Legal documentation for name change (marriage cert., divorce decree, court order, etc.), if applicable
- Letter from Dean of Educational Facility

Have submitted directly to the Board office address above from the issuing agent:

- Federation Credentials Verification Service (FCVS) – Primary Source Verification
- Certified transcripts from your medical school
- License Verification from each state medical board by which you are currently or have ever been licensed
- Three letters of recommendation
- American Medical/Osteopathic Association Physician Profile (AMA or AMO)

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: ____

Since your initial licensure, have you 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 No.: _____ Email: _____

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

Social Security No.: _____ Race: _____ Gender: ☐ Female ☐ Male
(for statistical purposes only) (for statistical purposes only)

School Name: _____ School Phone: _____

School Address: _____

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 training or clinical training. Attach additional sheet(s) if needed.

Institution/Program	Location (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Graduation/Program Completed?	Degree Earned

Are you a graduate from a medical school located outside of the United States or Canada? ☐ Yes ☐ No

If yes, ECFMG Certificate No.: _____

Is this a permanent certificate? ☐ Yes ☐ No

RECORD OF EXAMINATION

Complete the requested information below if licensure examination was taken in this state or any other state. List all examination (National Boards, FLEX, USMLE, etc.) attempts below. Attach additional sheet, if necessary. Do not include ABMS/AOA board certification.

Name of Examination	Location (State or Country)	Date of Exam	Passed/Failed Score

RECORD OF LICENSURE

List all states in which you have been licensed for any medical profession; regardless of status: Active, Inactive, Expired, Training etc. You will need to contact each state board and request a License Verification to be mailed directly to the SC Board of Medical Examiners at the above listed address. We provide a Verification of Licensure form as a courtesy; however, we will accept a state board issued form. Attach additional sheet if needed.

State/Jurisdiction	License No.

State/Jurisdiction	License No.

State/Jurisdiction	License No.

PERSONAL HISTORY QUESTIONS

If you answer "yes" to any of the questions below, submit a detailed letter of explanation along with any other relevant documentation.

1. Has your medical license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a medical licensing board or other entity? ☐ Yes ☐ No
2. Have you ever had an application to practice medicine denied or refused by another medical licensing board or other entity? ☐ Yes ☐ No
3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way? ☐ Yes ☐ No
4. Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration? ☐ Yes ☐ No
5. Have you ever 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. Have you ever had a malpractice lawsuit or judgment filed against you or settled a medical malpractice claim? If yes, how many? _____
   (Complete a Malpractice Claim Information form for each claim) ☐ Yes ☐ No
8. 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 Recovery 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. Have you ever discontinued the practice of medicine for any reason for three consecutive months or more? ☐ Yes ☐ No
10. Was your medical education/residency training interrupted other than for vacation periods or military service? ☐ 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. Have you ever been convicted, pled guilty or pled nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? ☐ Yes ☐ No

LETTERS OF RECOMMENDATION

Please supply below names and addresses of three physicians willing to write letters of recommendation to support your application for South Carolina medical licensure. **You must request that each physician listed below write directly to the Board** 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. The letters must be signed by the physician writing on your behalf. Make note of the reference number and physician's name listed for when you check your application status later.

Reference 1.

Name: _____ Phone: _____

Address: _____

Street, City, State, Zip

Reference 2.

Name: _____ Phone: _____

Address: _____

Street, City, State, Zip

Reference 3.

Name: _____ Phone: _____

Address: _____

Street, City, State, Zip

CERTIFYING STATEMENT

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 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

Subscribed and sworn to before me this ____ day

of _____ 20_____ .

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____

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

(Notary Seal)

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)

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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: _____