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

REQUIREMENTS FOR LIMITED LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

An applicant for limited licensure in South Carolina must comply with Section 40-47-950.

(A) The Board may issue a limited physician assistant license to an applicant who has:

(1) submitted a completed application on forms provided by the Board;
(2) paid the non-refundable application fee;
(3) successfully completed an educational program for physician assistants approved by the American Medical Association Counsel on Medical Education;
(4) never previously failed two consecutive NCCPA certifying examinations and has registered for, or intends to register to take the next offering of, the NCCPA examinations; (Insert 2)
(5) certified that he or she is mentally a physically able to engage safely in practice as a physician assistant;
(6) no licensure, certificate, or registration as a physician assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant's practice as a physician assistant;
(7) good moral character;
(8) submitted to the Board any other information the Board considers necessary to evaluate the applicant's qualifications;
(9) Criminal Background Check: Board will forward instructions once application is received.

(B) A limited license is not renewable and is valid only until the results of a limited licensee's two consecutive NCCPA certifying examinations are reported to the board. When a limited licensee has failed two consecutive NCCPA certifying examinations, or fails one exam and does not take the NCCPA certifying examination at the next opportunity or, after applying for a limited license, fails to register for the next offering of the examination, the limited license is immediately void and the applicant is no longer eligible to apply for further limited licensure. (Insert 2)

(C) A licensee who supervises another practitioner shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of their respective profession or shall hold an active unrestricted academic license to practice medicine in this State. The supervising physician of a limited licensee must be physically present on the premises at all times when the limited licensee is performing any task. No on-the-job training, or task not listed on the application, may be approved for a limited license holder.

(D) Upon successful passage of the NCCPA examination, you may update to a permanent license by submitting a copy of your NCCPA certificate and an update fee of $120.

Include with your application:

- Check or money order in the amount of **$25** 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" professional photo (Passport Photo)
- Copy of your current NCCPA Certificate: Visit: www.nccpa.net to obtain "verify certificate" page.
- Limited PA Supervisor Agreement
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable

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

- Certification of Education Form or Official Transcripts
- License Verification from each state medical board that you are currently or have ever been licensed in.
- Criminal Background Check (CBC): Board will forward instructions once application is received.
- **Current letter of eligibility from the NCCPA regarding your eligibility to sit for the next available NCCPA examination (www.nccpa.net)**

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LIMITED LICENSE APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT

Include with your application:

- Check or money order in the amount of **$25** 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" professional photo (Passport Photo)
- Copy of your current NCCPA Certificate: Visit: www.nccpa.net to obtain "verify certificate" page.
- Limited PA Supervisor Agreement
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Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

APPLICANT INFORMATION

Last Name:____________________First:______________________Middle:_________________Suffix:________

Have you ever legally changed your name? ☐ Yes ☐ No Maiden 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: ____

Business Name: _______________________________________ Business Phone: _________________________

Fax: _____________________________ Email Address: ____

Date of Birth: _____________________ Social Security No.: ____________________________________

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

Race: ____________________________ Gender: ☐ Female ☐ Male
(For statistical purposes only) (For statistical purposes only)

Name: ______________________________

PROFESSIONAL EDUCATION INFORMATION

List in chronological order from date of college 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)	Attendance Dates (MM/YR – MM/YR)	Graduation/Program Completed?	Degree Earned

RECORD OF LICENSURE

List all states in which you have been licensed in 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 Medical Board at the above listed address. We provide a License Verification 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.

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 Month / Yr	TO Month / Yr	EMPLOYER NAME	OFFICE ADDRESS	TYPE OF PRACTICE

Name: ______________________________

PERSONAL HISTORY INFORMATION

If you answer yes to any of the below questions, you must attach a full written explanation.

1. Has your physician assistant license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by any licensing board or other entity? ☐ Yes ☐ No

2. Have you ever had an application to practice as a physician assistant 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, judgment filed against you or settled a medical malpractice claim? If yes, how many? ________ ☐ Yes ☐ No
   (Complete a Malpractice Information Claim Form for each claim)

8. Are you currently being treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant? ☐ Yes ☐ No

9. Do you currently have any mental illness (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) or any physical illness or condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant? ☐ Yes ☐ No

10. Within the past two (2) years, has your ability to practice medicine been impaired by any physical or mental illness or by the use of alcohol and/or drugs? ☐ Yes ☐ No

11. Have you ever discontinued practice as a physician assistant for any reason for three consecutive months or more? ☐ Yes ☐ No

12. Was your medical education/residency training interrupted other than for vacation periods or military service? ☐ Yes ☐ No

13. 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

14. 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

Name: ______________________________

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 as a physician assistant in South Carolina.

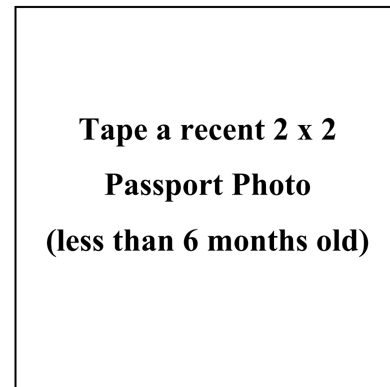
I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the 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 as a physician assistant 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: __________________________

(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.

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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: _________________

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SUPERVISION AGREEMENT FOR LIMITED PHYSICIAN ASSISTANT

WHEREAS, ______________________________________ (Applicant) has applied for a Limited License to practice as a Physician Assistant in South Carolina; and

WHEREAS, Applicant has provided documentation that he/she has never previously failed two consecutive National Commission on Certification of Physician Assistants' examination, and he/she has registered for or intends to register to take the next offering of this examination, and that he/she has graduated from a Physician Assistant training program approved by the American Medical Association; and

WHEREAS, Section 40-47-950 of the 1976 S.C. Code, as amended, setting forth the criteria for a Limited License; and

WHEREAS, this Statute explicitly states that if Applicant fails two consecutive NCCPA examinations or fails to register for the next scheduled NCCPA examination, the Limited License shall be "immediately void," and Applicant shall not be eligible for another Limited License; and

WHEREAS, this Statute further makes clear that the Applicant's supervising physician must be "physically present on the premises at all times" when the Applicant "is performing any task."

IT IS THEREFORE UNDERSTOOD AND AGREED THAT:

1) Pursuant to Physician Assistant Practice Act Section 40-47-950 (9), Applicant must appear with all original diplomas and certificates and demonstrated knowledge of the contents of this article; and

2) Applicant acknowledges and agrees that this Limited License is not renewable and is valid only until the results of a limited licensee's two consecutive NCCPA certifying examinations are reported to the Board. If a limited licensee has failed two consecutive NCCPA certifying examinations and fails to register for the next offering of the NCCPA examination, the limited license is immediately void and the applicant is no longer eligible to apply for further limited licensure.

3) Applicant further acknowledges and agrees that if he/she may not perform "on-the-job training" or any tasks not listed on the Physician Assistant application and that his/her supervising physician must be "physically present on the premises" at all times when he/she is performing any task.

4) Applicant further acknowledges and agrees that he/she has fully read this Agreement, is familiar with and fully understands the Physician Assistant Practice Act, and further fully understands and consents to the specific provisions and limitations of any Limited License that may be issued pursuant to Section 40-47-950.

5) Applicant further agrees that he/she will immediately notify this Board, in writing, of any change of address or change regarding the status of his/her supervising physician or employment relationship.

AND IT IS SO AGREED.

______________________________________ ______________________________
Physician Assistant Signature Date

______________________________________ ______________________________
Supervising Physician Signature Date

______________________________________ ______________________________
Interviewing Board Representative Signature Date