South Carolina Department of Labor, Licensing and Regulation
State Board of Medical Examiners for South Carolina
P.O. Box 11289 • Columbia, SC 29211
Phone: 803-896-4500 Fax: 803-896-4515
www.llronline.com/POL/Medical

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 Section 40-47-32 of the Medical Practice Act. Please visit the Board's website at www.llronline.com/pol/medical 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. If applicant has 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.

POSTGRADUATE TRAINING 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.
   - If 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;
   - 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; or
     - Foreign graduate 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.
   - 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 temporary license upon certification from the program of their good standing and expected satisfactory completion. (The board cannot issue a permanent license, until proof of 3 years of completed post graduate training has been received in the board office)

c. 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.

EXAMINATION REQUIREMENTS:

a. An applicant shall document to the satisfaction of the board successful completion of:
   - all parts of the National Board of Medical Examiners Examination in approved sequence;
   - all parts of the National Board of Osteopathic Medical Examiners Examination in approved sequence;
   - the Federation Licensing Exam (FLEX) based on standards established by the board;
   - the United States Medical Licensing Examination (USMLE) based on standards established by the board;
   - the Medical Council of Canada Qualifying Examination (MCCQE) in approved sequence;
   - the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA);
   - a written state examination of another state medical, osteopathic, or composite board prior to 1976, and current certification by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or another organization approved by the board; or

b. Combinations of the FLEX, National Board of Medical Examiners, and USMLE acceptable to the Composite Committee of the USMLE and approved by the board. These combinations may be accepted only if taken before 1999.

   - For FLEX examinations taken **before** June 1, 1985, the following standards apply:

     (a) An applicant for permanent licensure shall obtain, in one sitting; a FLEX weighted average score of at least seventy-five on the examination.

     (b) FLEX examinations taken before June 1, 1985 were administered in three days and the days were referred to as Day 1, Day 2, and Day 3. In case of failure, the results of the first three takings of each day must be considered by the board, and the board may consider the results from a fourth taking of any day; 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 Day 1, Day 2, or Day 3, 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.

   - For FLEX examinations taken **after** June 1, 1985, the following standards apply:

     (a) An applicant for permanent licensure shall obtain a score of seventy-five or more on both Components I and Component II. An applicant shall pass both components within five years of the first taking of any component of this examination.

     (b) FLEX examinations taken after June 1, 1985 were administered as Component I and Component II. In case of failure, the results of the first three takings of each component must be considered by the board. The board may consider the results from a fourth taking of any component; 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 Component I or Component II, 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.

   - 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.

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.

STATE AGENCY WAIVER:

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 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.

PRIMARY SOURCE VERIFICATION:

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 e-mail fcvs@fsmb.org to request your Physician Information Profile.

CRIMINAL BACKGROUND CHECK (CBC):

An applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in Section 40-47-36 of the Medical Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received.

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 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.

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.

It is a violation of state law if a physician practices medicine before being issued a license. Violators are subject to fines and possible criminal prosecution.

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 www.llronline.com/pol/medical and select **Application Status**.

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Application to Practice Medicine

Include with your application:

- Check or money order in the amount of $580 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 Drivers License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s), if applicable
- Legal documentation for name change

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

- 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.
- Criminal Background Check (CBC) - Board will forward instructions once application is received.
- 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

I. APPLICANT INFORMATION:

Title: ☐ M.D. ☐ D.O.

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:_____ 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)

Name: _____

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

_____

_____

_____

_____

II. 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)	Attendance Dates (MM/YR – MM/YR)	Graduation/Program Completed?	Degree Earned

1. 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 ☐

III. INTERSHIP 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?

IV. RECORD OF EXAMINATION

Complete the requested information below if licensure examination was taken in this state or any other state. List each 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

V. 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.

VI. MEDICAL SPECIALTY AND SC 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 (**If yes, attach a copy of the certificate)**:**
   If yes, date of certification/recertification: _____
   - ☐ American Board of Medical Specialties (ABMS)
   - ☐ American Osteopathic Association (AOA)

Name: _____

VII. 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

VIII. PERSONAL HISTORY INFORMATION

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

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, judgment filed against you or settled a medical malpractice claim? If yes, how many? _____
   (Complete a Malpractice Information Claim Form for each claim)

   YES ☐ NO ☐

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?

   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 of practice?

   YES ☐ NO ☐

Name: _____

Personal History Questions Continued…

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 the practice of medicine 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 ☐

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.

Name: _____

X. 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 medicine 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)

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: _____

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.

Date: _____ Signature: _____

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VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever have been licensed to practice medicine. You may want to contact each state to see if a fee is required.

In applying for a license to practice medicine in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature: _____

Name: _____

Address: _____

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____ Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Licensed by: ( ) National Board ( ) FLEX Exam ( ) USMLE ( ) State Board Exam ( ) Other: _____

Is license current ☐ Yes ☐ No If no, why not? _____

Has license been suspended, revoked, or restricted? ☐ Yes ☐ No If yes, why? _____

Comments, if any: _____

Date: _____ Signature: _____

Print name: _____

Board Seal Title: _____

Board: _____