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 TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER
UPDATE LICENSE

Include with your application:

- Check or money order (no cash) in the amount of $80 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 CRT or RRT National Board Certificate or examination results
- Physician Sponsor Statement, if performing home care duties
- Copy of Respiratory Care Diploma or have an official transcript sent to the Board
- 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.

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

License No.: _____

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: ____

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: _____

BUSINESS INFORMATION
(If known, otherwise mark "unknown at this time")

SC Medical Director: _____

Business Name: _____

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

Business Phone: _____ Business Email: _____

1. Do you plan to care for cardio-pulmonary patients in a home care setting? ☐ Yes ☐ No

   If Yes, you must attach a statement signed by your physician sponsor detailing the duties that you will perform and the type of supervision you will receive in performing these duties.

EDUCATION INFORMATION

List in chronological order from date of graduation all professional education. Attach a copy of your Respiratory Care Diploma or have an official transcript sent directly to the Board from your school. If additional space is needed, you may attach an additional sheet.

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

RECORD OF EXAMINATION

Complete the requested information below if any national or state licensure examination was taken for respiratory care. A copy of you CRT or RRT National Board Certificate or examination results must be included with this application. Verification directly from National Board for Respiratory Care (NBRC) may be required if appropriate documentation is not provided. Provide a written explanation if certificate is not attached.

1. Have you taken the entry level or higher level National Board for Respiratory Care examination? ☐ Yes ☐ No

Name of Examination (Include level, if applicable)	Registry/Certification Number (if applicable)	Location	Date of Exam	Passed/Failed Score
CRT				
RRT				

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 employment relevant to training and/or work experience in respiratory 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/YY)	To (MM/YY)	Employer Name	Office Address	Type of Practice

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. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony of any kind or a non-felony crime involving drugs or moral turpitude? ☐ Yes ☐ No

2. Has any Order or other disciplinary action been rendered against you by any state medical board (other than SC Board) or have you been denied licensure/certification by any other medical board or licensing authority? ☐ Yes ☐ No

3. Have any hospital privileges been revoked, suspended, restricted, denied or voluntarily surrendered? (Include the relinquishment of privileges while under investigation or pending action for any reason. Do not include the relinquishment of privileges as a result of a personal decision.) ☐ Yes ☐ No

4. Has your ability to practice respiratory care been impaired by any physical, emotional or mental illness, whether temporary or permanent? ☐ Yes ☐ No

5. Have you developed any disease or conditions, physical, mental or emotional (i.e. bipolar disease, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice? (If you have voluntarily enrolled in Recovering Professionals Program (RPP) and have remained in full compliance, you may answer "No". ☐ Yes ☐ No

6. Have you been discharged involuntarily from employment? ☐ 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.

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 Respiratory Care Practitioner 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 Respiratory Care Practitioner 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_____.

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

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____

(Notary Seal)

NOTE:
Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, license verifications, etc.

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)