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

# Reactivation Requirements

A person with an inactive license to practice medicine in this State who wishes to resume active practice shall submit an application for reactivation including:

**Include with your application:**

- Check or money order in the amount of $460 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)
- Notarized Verification of Lawful Presence (attached)
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s), if applicable
- Legal documentation for name change
- Documentation of Continued Competency (See attached Section 40-47-40)

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

- 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 AOA)

**Malpractice Form:** If applicable, complete and return the enclosed malpractice form with the requested information to the board if you have ever been named in a malpractice suit or settlement.

**Verification of Licensure** – A verification form is enclosed and may be duplicated as needed. This board must receive a verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice medicine.

**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.

**Criminal Background Check (CBC) -** An applicant for an initial license or reactivation to practice medicine in South Carolina shall be subject to a criminal history background check as defined in 40-47-36 of the Medical Practice Act. The Board will send you instructions once your application is received.

# 40-47-40. Continued Competency

The continued professional competency of a physician holding a permanent license must be demonstrated in the following manner:

(1) **For renewal of a permanent license initially issued during a biennial renewal period**, compliance with all educational, examination, and other requirements for the issuance of a permanent license is sufficient for the first renewal period following initial licensure.

(2) **For renewal of an active permanent license biennially**, documented evidence of at least one of following options during the renewal period is required:

(a) forty hours of Category I continuing medical education sponsored by the American Medical Association, American Osteopathic Association, or another organization approved by the board as having acceptable standards for courses it sponsors, at least thirty hours of which must be related directly to the licensee's practice area;

(b) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification;

(c) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association;

(d) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination; or

(e) successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians.

(3) **For reinstatement or reactivation of a permanent license from lapsed or inactive status of less than four years,** documented evidence of at least one of the following options within the preceding two years is required:

(a) forty hours of Category I continuing medical education sponsored by the American Medical Association, American Osteopathic Association, or another organization approved by the board as having acceptable standards for courses it sponsors, at least thirty hours of which must be directly related to the licensee's practice area;

(b) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification;

(c) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association;

(d) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination; or

(e) successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians.

(4) **For reinstatement or reactivation of a permanent license from lapsed or inactive status of four years or more**, documented evidence of at least one of the following options within the preceding two years is required:

(a) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification;

(b) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association;

(c) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination; or

(d) successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians.

(5) **For reinstatement or reactivation of a lapsed or an inactive status of a permanent license of a licensee who has been in active practice in another state**, compliance with any of the requirements of this section within the preceding two years is sufficient.

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# Reactivation Application to Practice Medicine

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- 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:**

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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. Prior License Number: _____

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)

## 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 |
|---|---|---|---|---|
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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. 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. |
|---|---|---|---|---|---|
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## IV. 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 you were certified/recertified: _____

   ☐ American Board of Medical Specialties (ABMS)

   ☐ American Osteopathic Association (AOA)

## V. 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
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## VI. 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. 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 ☐

**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.

## VII. 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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# VERIFICATION OF LICENSURE FORM

***Use this form only if it is required by another state.***

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.

Applicant's Signature: _____

Print Name: _____

Address: _____

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**FOR STATE BOARD TO COMPLETE**

**This section to be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners. You may send a state issued license verification in lieu of this form.**

Full name of licensee: _____

Graduate of: _____ Date of Degree: _____

State of: _____ License No.: _____ Date Issued: _____

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: _____

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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: _____