



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

**2021-2023 LATE RENEWAL APPLICATION FOR PHYSICIANS**

**Renewal Instructions/Requirements:**

- Check or money order only (no cash) in the amount of \$155 made payable to the S.C. Board of Medical Examiners. (All fees are non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.)
- Practice is not allowed after June 30, 2021.
- After June 30, 2021, licenses will lapse and be subject to a \$100 per month late fee until June 30, 2022.
- Include a \$500 penalty fee for CME hours completed after June 30, 2021.
- If you practiced after June 30, 2021, include a \$1,000 per month penalty fee.
- Submit documentation of 40 CME hours dated July 1, 2019 – June 30, 2021 with this renewal application. All 40 CME hours must be completed before submitting your renewal (40 total = 30 specialty, 10 may be non-specialty, 2 must be in prescribing and monitoring of controlled substances).
- July 1, 2022, reactivation application is required.
- Practice Activity Statement is incorporated into this renewal form and required to be completed and notarized.
- “SC Code 40-47-41(C) A licensee shall notify the Board in writing within fifteen business days of any change or residential address, office address, or office telephone number.” Failure to maintain a current address could result in important correspondence not reaching you.
- 81-1. Safeguarding Patient Medical Records When a Physician Licensee is Incapacitated, Disappears, or Dies. (A) Each physician licensee actively practicing within the State of South Carolina shall designate a partner, personal representative, or other responsible party to assume responsibility for patient medical records in the case of incapacity, death or disappearance of the licensee, including any circumstances whereby the licensee is unable for any reason to provide continuity of care, appropriate referral or patient medical records upon a valid request of the patient. Each physician licensee must affirm that he or she has read and understands this obligation upon application for initial licensure and application for renewal of licensure.

If you would like your name added to the SC Statewide Emergency Registry of Volunteers, please visit: [www.scserv.gov](http://www.scserv.gov).

SC License No.: \_\_\_\_\_

Note for SC Residents: To find your Congressional District you may go to: <http://www.scstatehouse.gov/legislatorssearch.php>

**LICENSEE INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Since you were licensed, 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.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email: \_\_\_\_\_

Are you a resident of SC?  Yes  No

Do you have an active or inactive license in another state?  Yes  No

Are you currently in a residency training or fellowship program?  Yes  No

Specify training program: \_\_\_\_\_

Do you plan to be in the military during the coming year?  Yes  No

United States:  Air Force  Army  Coast Guard  Marine Corps  Navy

**Activity Status (Check one only):**

- Active Practice, in SC  Active Practice, Out-of-State: \_\_\_\_\_
- Active Practice, Volunteer work only  Not Currently Practicing, Disabled
- Not Currently Practicing, Seeking Licensed Practice  Resident-in-Training
- Not Currently Practicing, Not Seeking Licensed Practice  Retired  Other

Do you use telemedicine to deliver services to patients located in South Carolina?  Yes  No

**PRIMARY EMPLOYMENT INFORMATION**

Business Name (Primary Place of Practice): \_\_\_\_\_

Check here if your position at your primary place of practice is best described as "Hospitalist"

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Bus. County: \_\_\_\_\_ Bus. Phone No.: \_\_\_\_\_ Bus. Fax No.: \_\_\_\_\_

Bus. Email: \_\_\_\_\_ Avg. Hours/week: \_\_\_\_\_

Is your Primary Place of Practice owned by a hospital or health system?  Yes  No

**Primary Practice Setting (Where patients are seen):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 44 Admin/Regulatory Hlth Agency | <input type="checkbox"/> 50 Business Establishment         | <input type="checkbox"/> 20 Com Hlth Ctr/Rural Hlth Cln |
| <input type="checkbox"/> 21 Fed Military Hlth Facility   | <input type="checkbox"/> 22 Fed Non-Military Hlth Facility | <input type="checkbox"/> 27 Free-Standing Amb Surg Ctr  |
| <input type="checkbox"/> 13 Free-Standing Clinic         | <input type="checkbox"/> 29 Free-Standing ER/Urgent Care   | <input type="checkbox"/> 11 Hosp, Non-Fed General       |
| <input type="checkbox"/> 23 Hosp, Non-Fed Psy            | <input type="checkbox"/> 24 Hospital, Non-Fed Rehab        | <input type="checkbox"/> 14 Outpat Mental Hlth Cln      |
| <input type="checkbox"/> 15 Private Office               | <input type="checkbox"/> 31 Univ/College of Med            | <input type="checkbox"/> 71 Other                       |

**Form of Practice (Source of Income):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 32 County Government      | <input type="checkbox"/> 34 Fed Civilian (Incl. USPHS)  | <input type="checkbox"/> 35 Fed Military                 |
| <input type="checkbox"/> 28 Non-Profit Hlth Agency | <input type="checkbox"/> 25 Other Private Emp           | <input type="checkbox"/> 43 Resident/Intern Training     |
| <input type="checkbox"/> 11 Self, Solo             | <input type="checkbox"/> 13 Self, Group, Same Specialty | <input type="checkbox"/> 14 Self, Group, Multi-Specialty |
| <input type="checkbox"/> 33 State Gov              | <input type="checkbox"/> 44 Volunteer                   | <input type="checkbox"/> 42 Other                        |

**SECONDARY EMPLOYMENT INFORMATION**

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Bus. County: \_\_\_\_\_ Bus. Phone No.: \_\_\_\_\_ Bus. Fax No.: \_\_\_\_\_

Bus. Email: \_\_\_\_\_ Avg. Hours/week: \_\_\_\_\_

**Second Practice Setting (Where patients are seen):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 44 Admin/Regulatory Hlth Agency | <input type="checkbox"/> 50 Business Establishment         | <input type="checkbox"/> 20 Com Hlth Ctr/Rural Hlth Cln |
| <input type="checkbox"/> 21 Fed Military Hlth Facility   | <input type="checkbox"/> 22 Fed Non-Military Hlth Facility | <input type="checkbox"/> 27 Free-Standing Amb Surg Ctr  |
| <input type="checkbox"/> 13 Free-Standing Clinic         | <input type="checkbox"/> 29 Free-Standing ER/Urgent Care   | <input type="checkbox"/> 11 Hosp, Non-Fed General       |
| <input type="checkbox"/> 23 Hosp, Non-Fed Psy            | <input type="checkbox"/> 24 Hospital, Non-Fed Rehab        | <input type="checkbox"/> 14 Outpat Mental Hlth Cln      |
| <input type="checkbox"/> 15 Private Office               | <input type="checkbox"/> 31 Univ/College of Med            | <input type="checkbox"/> 71 Other                       |

Secondary location practice specialty: \_\_\_\_\_

**TERTIARY EMPLOYMENT INFORMATION**

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Bus. County: \_\_\_\_\_ Bus. Phone No.: \_\_\_\_\_ Bus. Fax No.: \_\_\_\_\_

Bus. Email: \_\_\_\_\_ Avg. Hours/week: \_\_\_\_\_

**Tertiary Practice Setting (Where patients are seen):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 44 Admin/Regulatory Hlth Agency | <input type="checkbox"/> 50 Business Establishment         | <input type="checkbox"/> 20 Com Hlth Ctr/Rural Hlth Cln |
| <input type="checkbox"/> 21 Fed Military Hlth Facility   | <input type="checkbox"/> 22 Fed Non-Military Hlth Facility | <input type="checkbox"/> 27 Free-Standing Amb Surg Ctr  |
| <input type="checkbox"/> 13 Free-Standing Clinic         | <input type="checkbox"/> 29 Free-Standing ER/Urgent Care   | <input type="checkbox"/> 11 Hosp, Non-Fed General       |
| <input type="checkbox"/> 23 Hosp, Non-Fed Psy            | <input type="checkbox"/> 24 Hospital, Non-Fed Rehab        | <input type="checkbox"/> 14 Outpat Mental Hlth Cln      |
| <input type="checkbox"/> 15 Private Office               | <input type="checkbox"/> 31 Univ/College of Med            | <input type="checkbox"/> 71 Other                       |

Tertiary location practice specialty: \_\_\_\_\_

**ALL PRACTICE ACTIVITIES**

**Hours Per Week:**

**Enter the approx. hours per week spent in practice across all locations**

**Total Hours:** \_\_\_\_\_

- |                               |                         |
|-------------------------------|-------------------------|
| • Patent Care Hours: _____    | • Research Hours: _____ |
| • Administration Hours: _____ | • Training Hours: _____ |
| • Teaching Hours: _____       | • Other Hours: _____    |

**Hours Per Week Spent In Specialties:**

**Should equal to Total Hours listed above (enter the approx. total hours per week in all specialties, across all practice locations)**

- |                              |                                     |
|------------------------------|-------------------------------------|
| • Primary Specialty: _____   | Hours in Primary Specialty: _____   |
| • Secondary Specialty: _____ | Hours in Secondary Specialty: _____ |
| • Third Specialty: _____     | Hours in Third Specialty: _____     |

**List all South Carolina hospital affiliations you presently have:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Do you perform office-based surgery as defined in S.C. Code Regs 81-96?  Yes  No

If Yes, you must register with the board. Please see the regulation for detail.

## CONTINUING EDUCATION (CE)

ALL 40 CME hours must be completed before submitting your renewal (40 total = 30 specialty, 10 may be non-specialty, 2 must be in prescribing and monitoring of controlled substances). The Board will not maintain copies. A random audit will be conducted at the end of the renewal period requiring proof of CME documentation. To maintain your CME, licensees may submit their continuing education hours to CE Broker prior to renewing. You may activate your free CE Broker account using the following link: [www.cebroke.com/sc/account/basic](http://www.cebroke.com/sc/account/basic).

A list of approved Continuing Education Programs is available at [www.llr.sc.gov/med/](http://www.llr.sc.gov/med/)

Have you documented evidence of continuing education earned since July 1, 2019? (Licensees who are in their first renewal cycle after receiving their initial permanent license are not required to report continuing education for this renewal only. If this applies to you, please check yes.)

Yes  No

Have you documented evidence of completion of two (2) Category 1 CME hours (date range for completion 7/1/19 – 6/30/21) in approved procedures of prescribing and monitoring controlled substances? (Licensees who are in their first renewal cycle after receiving their initial permanent license are not required to report continuing education for this renewal only. If this applies to you, please check yes.)

Yes  No

## PERSONAL HISTORY QUESTIONS

If you answer Yes to any of the below questions, please attach a detailed written explanation along with any supporting documentation.

1. Since your last renewal (or if this is your first renewal since your initial license application), has any Order or other disciplinary action been rendered against you by any governmental professional licensing body (other than SC Board of Medical Examiners)?  Yes  No
2. Since your last renewal (or if this is your first renewal since your initial license application), have any hospital privileges or other professional privileges of any kind been revoked, suspended, restricted, denied, voluntarily surrendered or relinquished? (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
3. Since your last renewal (or if this is your first renewal since your initial license application), have you experienced 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” with respect to any condition involving abuse of alcohol or drugs.)  Yes  No
4. Since your last renewal (or if this is your first renewal since your initial license application), have you been convicted, pled guilty or nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude?  Yes  No
5. Since your last renewal (or if this is your first renewal since your initial license application), have you voluntarily restricted or curtailed your practice other than for retirement, family leave or vacation?  Yes  No
6. Since your last renewal (or if this is your first renewal since your initial license application), have you changed your specialty?  Yes  No
7. Since your last renewal (or if this is your first renewal since your initial license application), has there been any change in the status of your lawful presence in the United States?  Yes  No

**ATTESTATION**

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina licensure.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRIVACY NOTICE**

South Carolina law requires the agency to collect personal information which is only disseminated as required by law. 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 your renewal application and other documents on file 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 purposes.

**PRACTICE ACTIVITY STATEMENT MADE PURSUANT TO SC CODE 40-47-43**

Licensee Name: \_\_\_\_\_ License Number: \_\_\_\_\_

**I understand this is a sworn statement made under oath.**

**I hereby certify that: (Check one)**

- I **have not** practiced medicine in South Carolina since the lapse of my South Carolina medical license on June 30, 2021.
- I **have** practiced medicine in South Carolina since the lapse of my medical license on June 30, 2021.

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina licensure.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Signature: \_\_\_\_\_

Print Notary Name: \_\_\_\_\_

Notary Public for the State of: \_\_\_\_\_

Commission Expiration Date: \_\_\_\_\_

{Seal}

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**MD/DO Permanent  
Renewal Penalty Schedule**

<p><b>\$155.00 renewal fee + \$100.00 additional late fee per month.</b></p> <p><b>All CME must be dated 7/1/2019 – 6/30/2021.</b></p>	<p><b>\$155.00 renewal fee + \$100.00 additional late fee per month +</b></p> <p><b>\$500 penalty fee added if any CME hours are completed after 6/30/2021.</b></p>	<p><b>\$155.00 renewal fee + \$100.00 additional late fee per month +</b></p> <p><b>\$500 penalty fee added if any CME hours are completed after 6/30/2021.</b></p> <p><b>\$1,000 penalty fee per month if you practiced medicine in South Carolina for unauthorized practice.</b></p>
July \$155+\$100 = \$255	July \$155+\$100+\$500 = \$755	July add \$1000
August \$155+\$200 = \$355	Aug \$155+\$200+\$500 = \$855	August add \$2000
September \$155+\$300 = \$455	Sept \$155+\$300+\$500 = \$955	September add \$3000
October \$155+\$400 = \$555	Oct \$155+\$400+\$500 = \$1055	October add \$4000
November \$155+\$500 = \$655	Nov \$155+\$500+\$500 = \$1155	November add \$5000
December \$155+\$600 = \$755	Dec \$155+\$600+\$500 = \$1255	December add \$6000
January \$155+\$700 = \$855	Jan \$155+\$700+\$500 = \$1355	January add \$7000
February \$155+\$800 = \$955	Feb \$155+\$800+\$500 = \$1455	February add \$8000
March \$155+\$900 = \$1055	Mar \$155+\$900+\$500 = \$1555	March add \$9000
April \$155+\$1000 = \$1155	Apr \$155+\$1000+\$500 = \$1655	April add \$10,000
May \$155+\$1100 = \$1255	May \$155+\$1100+\$500 = \$1755	May add \$11,000
June \$155+\$1200 = \$1355	Jun \$155+\$1200+\$500 = \$1855	June add \$12,000
<b>July 1, 2022 submit Reactivation application</b>	<b>July 1, 2022 submit Reactivation application</b>	<b>July 1, 2022 submit Reactivation application</b>