South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 12367 • Columbia • SC 29211-2367
Phone: 803-896-4550 • NURSEBOARD@llr.sc.gov • Fax: 803-896-4515
llr.sc.gov/nurse

REQUIREMENTS AND INSTRUCTIONS FOR ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSURE BY ENDORSEMENT

APPLICATION CANDIDATES:

This application is for a nurse practitioner (NP), certified nurse-midwife (CNM), certified registered nurse aesthetician (CRNA) or clinical nurse specialist (CNS) who is currently or was previously licensed as an APRN in another state.

REQUIREMENTS

An applicant for a license who currently holds or has held an authorization to practice in another state or jurisdiction in the country or territory or dependency of the United States may be licensed by the board by endorsement, without examination, if the applicant:

1. has met all qualifications for licensure as a registered nurse; and
2. holds current specialty certification by a board-approved credentialing organization.
   - New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion; and

3. has earned a master's degree from an accredited college or university, except for those applicants who:
   a. provide documentation as requested by the board that the applicant graduated from an advanced, organized formal education program appropriate to the practice and acceptable to the board before December 31, 1994; or

   b. graduated **before December 31, 2003**, from an advanced, organized formal education program for nurse anesthetists accredited by the national accrediting organization of that specialty.

   CRNA's who graduate **after December 31, 2003**, must graduate with a master's degree from a formal CRNA education program for nurse anesthetists accredited by the national accreditation organization of the CRNA specialty. An advanced practice registered nurse must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty; and

4. has a declared specialty area of nursing practice and the specialty title to be used must be the title which is granted by the board-approved credentialing organization or the title of the specialty area of nursing practice in which the nurse has received advanced educational preparation.

5. Submits verification of current or prior authorization to practice as an APRN and RN nurse in another state or jurisdiction or territory or dependency of the United State and that a license:

   a. has been issued on the basis of passing the State Board Test Pool Examination before 1983 or the appropriate National Council Licensure Examination;

b. was not issued on the basis of passing the State Board Test Pool Examination before 1983 or the appropriate National Council Licensure Examination, in which case the applicant shall demonstrate not fewer than three years of successful practice as a licensed nurse in another state or jurisdiction in this country without disciplinary action that resulted in restriction of practice, including probation.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS

An applicant for a license to practice nursing in South Carolina shall be subject to a criminal history background check as specified in section 40-33-25 of the Nursel Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received. DO NOT have your fingerprints or CBC report processed until you have submitted an application and received instructions from the Board.

- If you are applying with an alien registration number, you will not be able to have your fingerprints processed until you obtain a social security number.

EDUCATION:

Official transcripts from an accredited college or university where the applicant earned a master's degree. See Requirements section on the prior page for exceptions for nurse anesthetists and applicants who graduated before December 31, 2003.

Schools for all MSN or Doctorate programs must be approved by either the CCNE or the ACEN. You must have a national certification for the specialty area of nursing practice.

NATIONAL CERTIFICATION FOR SPECIALTY AREA OF PRACTICE

You must have a national certification for the specialty area of nursing practice. You may include proof of national certification with your application or have it sent directly to the SCBON.

- New graduates shall provide evidence of certification within one year of program completion.
- Psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion.

To see a list of approved certification organizations, please visit this link:
https://www.llr.sc.gov/nurse/PDF/BoardApprovedAdvancedPracticeCertificationOrganizations.pdf

FOREIGN-EDUCATED APPLICANTS

For detailed information on foreign educated applicants, visit: https://llr.sc.gov/nurse/feducation.aspx. This process should be completed before making application with the SCBON due to time constraints and should be sent directly to the SCBON.

- You will need to submit a copy of your nursing license from country of original licensure.
- You will need to request a Credential Evaluation Report to be sent directly to the SC Board of Nursing. Visit Credential Evaluation Services for more detailed information on service providers.
- You must have passed the NCLEX.

RESIDENT ALIEN REGISTRATION

A foreign applicant may apply with a resident alien registration number, but a social security number is required before a Criminal Background Check can be processed and before a license will be issued.

TEMPORARY LICENSE:

You may apply for a sixty (60) day temporary license to practice nursing in SC if one or more of the below listed items is pending for an additional $10 fee. Prescription Authority is only available when a permanent license is issued. A temporary license is not available for applicants who answer yes to the personal history questions related to previous discipline, surrender/relinquishment of a professional license in lieu of discipline, safety to practice, and/or arrest/convictions.

- Criminal Background Check.
- Documentation of your national certification.
- Official License Verification.

You will need to provide proof of an active license to practice in another state or jurisdiction of the United States.

SAFEGUARDING PATIENT RECORDS

Each Advanced Practice Registered Nurse (APRN) licensee actively practicing within the State of South Carolina, in a solo practice setting, 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 APRN nurse licensee must identify by name, address, and telephone number their designee required by this regulation upon each application for initial licensure, renewal, and reinstatement.

OUT-OF-STATE LICENSE VERIFICATION

Verification of current or prior license to practice as an advanced practice registered nurse in another state is required.

You may visit https://www.nursys.com/ to request an electronic verification of your RN licensure by exam to be sent to the State Board of Nursing for South Carolina (SCBON). If the state is not a participating state of NURSYS, you will need to contact that state board directly and have a license verification sent directly to the SCBON.

Electronic verifications may be sent to the SCBON directly from the issuing state board via email: nurseboard@llr.sc.gov.

FEDERAL GOVERNMENT/MILITARY EMPLOYMENT

If you are in the military or do work for the Federal government and are currently licensed in another state, you are only required to apply for licensure if you intend to work outside of the military or Federal Government.

VERIFICATION OF LEGAL NAME

A license must be issued in the nurse's legal name as verified by a birth certificate or other legal document acceptable to the Board. Examples of acceptable documents include a valid passport, vital statistics birth certificate (not hospital birth certificate), marriage certificate, divorce decree or court order approving legal name change.

NOTIFICATION OF INITIAL EMPLOYMENT/CHANGE OF PRACTICE

The South Carolina Nurse Practice Act requires a licensed APRN (NP, CNM, CNS), who changes or discontinues primary practice settings or collaborating physicians to notify the board of this change within 15 business days and provide verification of a written practice agreement. A CRNA who changes or discontinues practice settings or physicians/dentists shall notify the Board of such change within 15 days and provide verification of written guidelines.

NURSE LICENSURE COMPACT
South Carolina is a member of the Nurse Licensure Compact (NLC). The NLC does not affect additional requirements imposed by states for advanced practice registered nursing. A multi-state licensure privilege to practice registered nursing granted by a party state must be recognized by other party states as a license to practice registered nursing if a license to practice registered nursing is required by state law as a precondition for qualifying for advanced practice registered nurse authorization.

A current APRN South Carolina license or temporary license is required to practice advanced nursing in this state. Orientation is considered the practice of nursing in South Carolina. Therefore, all nurses must possess a current South Carolina license and/or temporary license before beginning orientation (including classroom instruction and reading policies and procedures).

DECLARATION OF PRIMARY STATE OF RESIDENCE
The SC Nurse Practice Act allows an APRN to practice as an RN while their APRN license is in good standing. If you want to practice as an RN with multi-state privileges, you are required to submit the Declaration of Primary State of Residence form.

If you apply for licensure in advance of moving, your RN license will be a single-state license until you can provide the **Declaration of Primary State of Residence form** with a copy of your proof of residence. For more information, please visit the National Council of State Boards of Nursing (NCSBN) at https://www.ncsbn.org/.

"Primary state of residence" as defined by the NLC means the "*person's declared fixed permanent and principal home for legal purposes; domicile*."

Proof of primary residence must be established with one of the following:

1. Driver's license with a home address;
2. Voter registration card displaying a home address;
3. Federal income tax return declaring the primary state of residence.
4. Military Form #2058 – state of legal residence certificate; or
5. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

PRESCRIPTIVE AUTHORITY APPLICATION
The prescriptive authority application is a separate process from initial licensure. We recommend having your collaborating physician and written protocol in place before applying. The written protocol should not be submitted unless you are audited by the SCBON. The SCBON will notify you if you are being audited.

Visit https://llr.sc.gov/nurse/Online/APRNRX.aspx for detailed application requirements and instructions

INSTRUCTIONS

Include with your application:

- Check or money order made payable to LLR-South Carolina Board of Nursing (SCBON). 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 valid driver's license, state issued ID, passport or military ID.
- Copy of Social Security Card
- Notarized Verification of Lawful Presence.
- Copy of active out-of-state license (for temporary license applicants only.)
- Copy of current national advanced practice specialty certification
- 2" x 2" passport-type photo (Must be less than 6 months old.)
- Verification of legal name: (vital statistics birth certificate (not hospital birth certificate), valid passport, marriage certificate, divorce decree, or court order approving a legal name change)
- Initial Employment/Change of Practice Form. (If employment is known at the time of application.)
    - APRN Initial Employment/Change of Practice Form
    - CRNA Initial Employment/Change of Practice Form
- English proficiency report, if applicable.
- Declaration of Primary State of Residence Form, if applicable.
- Malpractice Claim Form, if applicable.

Have submitted directly to the SCBON from the issuing institution/agency:

- Official transcripts sent from education institution where master's degree was obtained. Information for foreign educated nurses can be found at: llr.sc.gov/nurse/feducation.aspx
- Official license verification of RN and current/prior APRN license.
- **Criminal Background Check**: Instructions will be sent via email to you **AFTER** your application has been received. Do not have your CBC processed beforehand; it may be purged if your application is not on file and you will need to pay to have a new one sent.

APPLICATION STATUS

Applications for licensure are valid for one year from the date of filing with the board. An applicant who fails to attain licensure during this period shall submit a new application, application fee, CBC, and required documentation.

Applications are processed (reviewed) in the order they are received. Once your application is processed, you will be emailed a status update and instructions on how to have your CBC processed. The email will be sent to the email address you have provided at the time of application.

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APPLICATION FOR ADVANCE PRACTICE REGISTERED NURSE (APRN) LICENSURE BY ENDORSEMENT

Applying for: (check one) ☐ **$140 Endorsement** ☐ **$150 with Temporary License**

Type of License: **Nurse Practitioner** **Certified Nurse-Midwife**

Certified Registered Nurse Anesthetist **Clinical Nurse Specialist**

If you have previously held a SC APRN license, please fill out the APRN Reactivation/Reinstatement application.

APPLICANT INFORMATION:

Last Name:____________________ First:____________________ Middle: ____________ Suffix: _____

Have you ever legally changed your name? ☐ YES ☐ NO Maiden/Prior Name:__________________

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, or court order.)

Home Address: ________________________City:___________State:_____Zip:__________District:_____
Congressional District (SC Residents Only)

SC Residents to find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

Mailing Address:__________________________________ City:_____________ State:_____ Zip:_____
(If different than above)

Phone: ________________________ Email Address *(required)*: ___________________________

Date of Birth:___________________ Social Security No.: ________________________________

Race: _________________________ Gender: ☐ Female ☐ Male
(for statistical purposes only)

Place of Birth: ______________________________

PRIMARY STATE OF RESIDENCY

The Nurse Practice Act allows an APRN to practice as an RN while their APRN license is in good standing. If you want to practice as an RN with multi-state privileges, you are required to submit the Declaration of Primary State of Residence.

1. Do you want multi-state privileges as an RN? YES NO

PROFESSIONAL EDUCATION INFORMATION

Have an official transcript sent directly to the SCBON from your master's nursing education program.

School of Master's Education: ________________________ Date of Graduation: _____________

Location: ____ Degree Earned: _________________

FOREIGN EDUCATED APPLICANTS ONLY

1. Are you a graduate from a nursing education program located outside of the United States? YES NO
   a. If yes, have you contacted a credential evaluation service provider for an education evaluation report to be sent to the SCBON? YES NO

   This process should be completed before making application with the SC Board of Nursing (SCBON) due to time constraints and should be sent directly to the SCBON.

ENGLISH PROFICIENCY

An applicant whose native language is not English shall submit evidence of passing an English proficiency exam administered by a board approved service. Visit https://llr.sc.gov/nurse/EnglishProficiency.aspx for a list of acceptable exemptions.

1. Is English your native language? YES NO
   a. Have you taken and passed an English proficiency examination? YES NO
   b. Do you qualify for an exemption to the English proficiency exam as described on the English proficiency page? YES NO

NATIONAL CERTIFICATION FOR SPECIALTY AREA OF PRACTICE

You must have a national certification for specialty area of nursing practice. You may include proof of national certification with your application or have it sent to the SCBON.

- New graduates shall provide evidence of certification within one year of program completion.
- Psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion.

1. What is your specialty area of APRN practice: ______________________________

   Certifying Organization: ________________________ Expiration Date: ________________

OUT-OF-STATE/PRIOR LICENSURE

Verification of current or prior license to practice as an advanced practice registered nurse in another state is required.

You may visit https://www.nursys.com/ to request an electronic verification of your RN licensure by exam to be sent to the State Board of Nursing for South Carolina (SCBON). If the state is not a participating state of NURSYS, you will need to contact that state board directly and have a license verification sent directly to the SCBON.

State where you were licensed as an RN by exam (NCLEX): _________________

State:_______ Type of License: _________ License Number: _______________

State:_______ Type of License: _________ License Number: _______________

SAFEGUARDING PATIENT RECORDS

If you know that you will be practicing in a solo practice setting you will need to provide the name of a designated partner, personal representative or other responsible party that will assume responsibility for patient medical records if necessary. If unknown, you may answer "no."

1. Will you be practicing within South Carolina in a solo practice setting? YES NO
   If yes, the information below is required.

Designee/Responsible Partner Name: ______________________________ Contact Phone: ____________________

Full Address: ____

PERSONAL HISTORY INFORMATION

Please respond to all questions. If you answer "Yes" to any question, you must attach a written explanation. In addition, if you answer "Yes" to any question, you may be requested to appear before the full Board to answer additional questions and/or provide additional information.

If you answer yes to any of the questions below, you are not eligible to receive a temporary license.

1. Have you had any application for any professional license, certification, or registration refused or denied by any licensing authority? YES NO

2. Have you been refused or denied the privilege of taking an examination required for any professional license? YES NO

3. Have you had any professional license revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a professional licensing board or other entity? YES NO

4. Have your privileges ever been restricted or terminated by any association or licensed facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures? YES NO

5. 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

6. Have you ever voluntarily surrendered or relinquished a nursing license, controlled substance registration or DEA registration? YES NO

7. To your knowledge, are you currently under investigation or the subject of pending disciplinary action by any federal or state agency, professional association, licensed hospital or clinic, or other entity? YES NO

8. Have you ever had a malpractice lawsuit filed against you, a judgment returned/filed against you, or settled a medical malpractice claim? YES NO
   If yes, how many? ________
   (Complete a Malpractice Information Claim Form for each claim)

9. Have you ever been arrested, charged or convicted (including a nolo contendere plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? Note: A DUI is not a minor traffic violation. YES NO

   If yes, attach a certified copy of the court records regarding your arrest, charge and/or conviction, including the nature of the offense and the date of discharge. If applicable, have a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities.

10. 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? YES NO

    (If you are voluntarily enrolled in the Recovering Professional 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".)

11. Have you voluntarily surrendered or relinquished a professional license in lieu of discipline? YES NO

ATTESTATION

I, ______________________________________, am the person described and identified and the person named in all documents presented in support of this application.

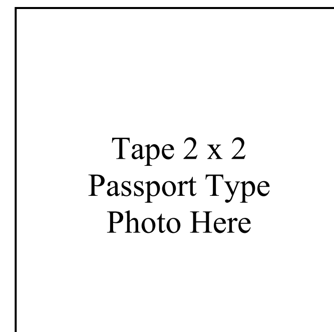
I have carefully read the questions within this application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct to the best of my knowledge and belief.

Should I furnish any false, incomplete, or misleading information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license in South Carolina.

I certify I am the person shown in the photograph below and it has been taken within the last 6 months.

____
Applicant Signature

____
Print Applicant Name

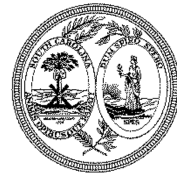


Privacy Disclosure

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.

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: _________________________________

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.

______________________________ ______________________________
Nurse 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 Nurse ☐ Group ☐ Hospital

List names of other defendant doctors, nurses and/or hospitals:

____

____

____

DISPOSITION: ☐ Pending ☐ Jury Verdict ☐ Settled ☐ Dismissed ☐ Dropped

If the lawsuit against you was dismissed, was it dismissed by the Court on the merits or was it dismissed as a result of settlement negotiations before settlement?
☐ On the merits ☐ Dismissed before settlement

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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DECLARATION OF PRIMARY STATE OF RESIDENCE FOR PURPOSES OF THE NURSE LICENSURE COMPACT

Please complete this form and include a copy of an approved proof of residence (listed below) by submitting with your application. You may also log your e-service account (https://eservice.llr.sc.gov/DocumentSubmission) if you need to update your existing license to add SC as your primary state of residence.

Visit the National Council of State Boards of Nursing website (www.ncsbn.org) for a list of states that have implemented the Compact.

"Home state" is defined as the state which is the nurse's primary state of residence. The Nurse Licensure Compact (NLC) requires each nurse to declare in writing a primary state of residence upon initial application and renewal of the nursing license. "Primary state of residence" means the state in which a nurse declares a principal residence for legal purposes. See SC Code 40-33-1320 for more information related to "home state."

Proof of primary residence must be established with one of the following:

1. Driver's license with a home address;
2. Voter registration card displaying a home address;
3. Federal income tax return declaring the primary state of residence.
4. Military Form #2058 - state of legal residence certificate; or
5. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

Name (as shown on license): ______________________________________ SC License No.:___________________
(If license has been issued.)

Address: _________________________________ City: ______________________State:_________ Zip:_________

Is this a change of address? Yes No Last 5-Digits of Social Security No.: ________________

DECLARATION

I hereby declare my primary state of residence is _______________________________.

By the signature below, I attest to the accuracy of the information provided.

Signature:____ Date:______________________

Note: If you are currently licensed as a South Carolina nurse, you may need to complete a new fingerprint criminal background check. You will be notified by email if you are subject to this requirement and notification will include instructions on how to have your fingerprints processed.

Advanced Practice Registered Nurse (APRN) (Nurse Practitioner, Certified Nurse Midwife, or Clinical Nurse Specialist)

New Employment / Change of Practice Request Form / Prescriptive Authority

(§40-33-34 (D) – APRNs must submit a change of practice form within 15 days of change)

Return this completed form by logging into https://eservice.llr.sc.gov/DocumentSubmission or email to nurseboard@llr.sc.gov for processing.

Select type of Advanced Practice that applies to you:

☐ **Nurse Practitioner (NP)** ☐ **Certified Nurse-Midwife (CNM)** ☐ **Clinical Nurse Specialist (CNS)**

Last Name	**First Name**	**Middle Name**	**Maiden Name**
Home Address (Street, City, State, Zip):		**Home Phone:**	
Last five of SSN:	**SC License #:**	**Specialty Area:**	

Reminder: All physicians can only work with no more than six (6) NPs, CNMs, CNSs, or PAs at any one time without prior approval by the SC Board of Medical Examiners. Updates/changes must be submitted to the Board within 15 days of change. If you have questions, please send an email to NurseBoard@LLR.SC.GOV.

☐ **New Employment** ☐ **Change of Practice Site(s)** ☐ **Change of Physician(s)**

☐ **Additional Practice Site(s)** ☐ **Additional Physician(s)** ☐ **Reinstatement of RX**

(If RX has been removed over 6 months, applicant must reapply for RX by submitting an application.)

☐ **Remove Physician(s)** **1.**_________________ Lic. #_______________ **2.**_______________ Lic. # ____________

3._________________ Lic. #_______________ **4.**_______________ Lic. # ____________

PRIMARY Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):** **Practice Address: (Street, City, State, Zip Code)**	
☐ **Primary Physician** ☐ **Alternate Physician**	**Collaborating Physician** (All physicians must have a permanent SC license in good standing) **Business Address: (Street, City, State, Zip)**	
SC Physician's License No:	**Practice Specialty:**	**Primary Practice Site Phone Number**

COLLABORATING PHYSICIANS MUST BE PHYSICALLY PRESENT AT A PRACTICE SITE LOCATED WITHIN THE GEOGRAPHIC BOUNDARIES OF S.C. CODE SECTION 40-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-195.

Signature of Collaborating Physician: **Date**

SECONDARY/ADDITIONAL Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):** **Practice Address: (Street, City, State, Zip)**	
☐ **Primary Physician** ☐ **Alternate Physician**	**Collaborating Physician** (All physicians must have a permanent SC license in good standing) **Business Address: (Street, City, State, Zip)**	
SC Physician's License No:	**Practice Specialty:**	**Secondary Practice Site Phone Number**

COLLABORATING PHYSICIANS MUST BE PHYSICALLY PRESENT AT A PRACTICE SITE LOCATED WITHIN THE GEOGRAPHIC BOUNDARIES OF SC. CODE SECTION 40-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-195.

Signature of Collaborating Physician **Date**

A copy of the written practice agreement, for NP, CNM, or CNS signed and dated by all the physicians listed above and myself are on file in the office/agency of my employment and available upon request. ☐ **YES** ☐ **NO**

Please do not send written practice agreements unless requested.

I HEREBY Swear/affirm the statements made in this document to be TRUE to the best of my knowledge.

____ ____________

Signature and Title of Applicant **Date**

Advanced Practice Registered Nurse (APRN) – Certified Registered Nurse Anesthetist (CRNA)

Change of Practice Request Form

(§40-33-34 (H)(4) – CRNAs must submit a change of practice form within 15 days of change)

Return this completed form by logging into https://eservice.llr.sc.gov/DocumentSubmission or email to nurseboard@llr.sc.gov for processing.

PLEASE DO NOT FAX.

Last Name	**First Name**	**Middle Name**	**Maiden Name**

Home Address (Street, City, State, Zip):	**Home Phone:**

Last five of SSN:	**SC License #:**	**Specialty Area:**

Nature of Change:

☐ **New Employment** ☐ **Change of Practice Site(s)** ☐ **Change of Physician/Dentist**

☐ **Additional Practice Site(s)** ☐ **Other (specify):** ____

☐ **Removal of Physician/Dentist 1.**________________ Lic. #________________ **2.**_______________ Lic. # ________________

PRIMARY Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):** **Practice Address: (Street, City, State, Zip Code)**
* Supervising Physician/Dentist: (of written guidelines) ☐ **Physician** ☐ **Dentist** ☐ **Medical Director**	**Supervising Physician/Dentist of Written Guidelines** (Must have a permanent SC license in good standing) **Business Address: (Street, City, State, Zip)**
SC Physician/Dentist's License No:	**Primary Practice Site Phone Number**

Signature of Supervising Physician/Dentist*: **Date:**

ADDITIONAL Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):** **Practice Address: (Street, City, State, Zip)**
* Supervising Physician/Dentist: (of written guidelines) ☐ **Physician** ☐ **Dentist** ☐ **Medical**	**Supervising Physician/Dentist of Written Guidelines** (Must have a permanent SC license in good standing) **Business Address: (Street, City, State, Zip)**
SC Physician/Dentist's License No:	**Secondary Practice Site Phone Number**

Signature of Supervising Physician/Dentist*: **Date:**

A copy of written approved guidelines signed and dated by the physician/dentist listed above and myself are on file in the office/agency of my employment and available upon request. ☐ **YES** ☐ **NO**

Please do not send written practice agreements unless requested.

I HEREBY Swear/affirm the statements made in this document to be TRUE to the best of my knowledge.

____ ________________

Signature and Title of Applicant **Date**