South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
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P.O. Box 12367 • Columbia • SC 29211-2367
Phone: 803-896-4550 • NURSEBOARD@llr.sc.gov • Fax: 803-896-4515
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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) (4) – APRNs must submit a change of practice form within 15 days of change)

Please email the completed PDF form to NurseBoard@LLR.SC.GOV for processing. PLEASE DON'T FAX.

Our forms are in portable document format (PDF) and require the Adobe Acrobat Reader to view and print. If you do not have of copy of the FREE Acrobat Reader, visit http://www.adobe.com.

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 given 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 e-mail 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**	**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**

Signature of Physician * ______________________ **Date** __________

By signing this document, I affirm that I will not work with any more than six (6) NPs, CNMs, CNSs, or PAs at any given time without prior approval by the SC Board of Medical Examiners, pursuant to S.C. Code Ann. 40-47-195(D)(1)(c).

SECONDARY/ADDITIONAL Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name:** **Practice Address: (Street, City, State, Zip)**	
☐ **Primary Physician** ☐**Alternate Physician**	**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**

Signature of Physician * ______________________ **Date** __________

By signing this document, I affirm that I will not work with any more than six (6) NPs, CNMs, CNSs, or PAs at any given time without prior approval by the SC Board of Medical Examiners, pursuant to S.C. Code Ann. 40-47-195(D)(1)(c).

A copy of the 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 the written Practice Agreement 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** __________