South Carolina Department of Labor, Licensing and Regulation
**South Carolina Board of Nursing**
P.O. Box 12367 • Columbia, SC 29211
Phone: 803-896-4550 • Fax: 803-896-4515 • www.llronline.com/POL/nursing/

# INSTRUCTIONS AND REQUIREMENTS FOR REINSTATEMENT / REACTIVATION SOUTH CAROLINA ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSE

## Information for Applicant

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 South Carolina APRN 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). It is a violation of the Nurse Practice Act to begin orientation without the proper license and can result in action by the Board. Please visit our website at www.llr.state.sc.us/pol/nursing to review the complete South Carolina Nurse Practice Act, Chapter 33, Section 40-33-34 for more details on educational and certification requirements.

**South Carolina Nurse Practice Act §40-33-20.** Definitions.
(31) "Inactive license" means the official temporary retirement of a person's authorization to practice nursing upon the person's notice to the board that the person does not plan to practice nursing or the status of a license that does not currently authorize a licensee to practice nursing in this State.
(34) "Lapsed license" means the termination of a person's authorization to practice nursing due to the person's failure to renew his or her nursing license within the renewal period.

The Board may reinstate/reactivate an APRN licensee from inactive/lapsed status upon payment of reactivation/ reinstatement fee and furnish evidence satisfactory that applicant has met requirements for licensure as provided in §40-33-34.

An applicant for licensure as an Advanced Practice Registered Nurse (APRN) shall furnish evidence satisfactory to the board that 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 was 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;
(4) has paid the board all applicable fees; and

(5) has 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.

**Prescriptive Authority:** APRN's applying for prescriptive authority shall meet the requirements as noted in the S.C. Nurse Practice Act, Section 40-33-34 (E).

**In order to change the status of your license from Inactive/Lapsed Status to Active Status, you must do the following:** Complete and submit the APRN reinstatement/reactivation application and if applicable, Prescriptive Authority application. **Application fees are non-refundable**. Money order, cashier's check or personal check should be made payable to **LLR-Board of Nursing**.

Your application must include the following:

1. Complete the Affidavit of Eligibility
2. Criminal Background Check (CBC): Board will forward instructions once application is received.
3. Recent 2"x 2" full faced passport type photo, sign and date on front or back and tape along top edge only onto your application.
4. Copy of your current state license
5. Copy of current specialty certification by a board-approved credentialing organization.
6. Copies of legal documents that authorize a change in name, if applicable.
7. Obtain all physician signatures and license numbers to be included on your application, if applicable.
8. See the SC Nurse practice Act for guidelines on the development of written protocols.
9. If applying for Prescriptive Authority, complete and submit the following: Prescriptive Authority Application and documentation of continuing education hours in pharmacotherapeutics
10. Application fees – Money order, cashier's check or personal check made payable to LLR-Board of Nursing.
    - APRN Reinstatement of lapsed license $90.00
    - APRN Reinstatement of lapsed license with Prescriptive Authority $110.00
    - APRN Reactivation of inactive license $70.00
    - APRN Reactivation of inactive license with Prescriptive Authority $90.00

## Criminal Background Check (CBC):

An applicant for a license to practice nursing in South Carolina shall be subject to a criminal history background check as defined in 40-33-25 of the Nursing Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received.

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# APRN REINSTATEMENT/ REACTIVATION APPLICATION

Check all that apply: ☐ **Reinstatement** ☐ **Reactivation** ☐ **Prescriptive Authority**

South Carolina is a member of the Nurse Licensure Compact (NLC). Advanced practice is recognized as a single state license only. Please visit www.ncsbn.org for more information or for a current list of Compact States. Please print. Answer all questions and submit with proper fee. Careful completion of this application will avoid a delay in processing. Personal information provided in this application may be subject to public scrutiny or released under the SC Freedom of Information Act or other provisions of federal and state law. The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the National Practitioner Data Bank (NPDB), among other things. The South Carolina Code of Laws requires that every individual who applies for an occupational or professional license provide a social security or alien identification 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.

*Social Security Number:*______-____-________

Full Legal Name:____________________________________________________________
First Middle Maiden (if married) Last

Mailing Address:____________________________________________________________
Street/PO Box City State Zip

Home Address:______________________________________________________________
Street (physical address required) City State Zip

County:_______________________________Email Address:___________________________________

Telephone #:_____________________ Date of Birth:______________ Place of Birth: _________________________

Race: (for statistical purposes only)

☐American Indian ☐African American ☐Caucasian ☐Hispanic ☐Oriental/Asian ☐Other

Marital Status: ☐Single ☐Married ☐Widowed ☐ Divorced Sex: ☐Female ☐Male

**Declaration of Primary State of Residence**: (where I hold a driver's license, pay taxes or vote)

I declare my primary state of residence is _____________I plan to primarily practice in the state of_____________

I am in the military or federal government. I am currently licensed in ___________ (state) and I do not intend to work outside of military or federal government.

Remit fee by money order, cashier check or personal check, made payable to LLR-Board of Nursing with application. For a legal name change, include documented proof (required- marriage license, divorce decree or court document). The application fee is non-refundable. Check only one box below.

☐ APRN Reinstatement of lapsed license $90.00
☐ APRN Reinstatement of lapsed license with Prescriptive Authority $110.00
☐ APRN Reactivation of inactive license $70.00
☐ APRN Reactivation of inactive license with Prescriptive Authority $90.00

Attach original recent 2 x 2 passport photo

Sign and date photo on left side

Tape on top edge only

Do not staple

Name_______________________________
www.llr.state.sc.us/pol/nursing

## Personal History Information

**If you answer "yes" to any of the questions below (1-10), you must attach a full written explanation pertaining to that particular question.**

| Question | Answer |
|---|---|
| 1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority? | **YES** ☐ **NO** ☐ |
| 2. Have you ever been refused or denied the privilege of taking an examination required for any professional license? | **YES** ☐ **NO** ☐ |
| 3. Have you ever been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility, or staff of such facility? | **YES** ☐ **NO** ☐ |
| 4. Have your privileges ever been restricted or terminated by any association, licensed facility, or staff of such 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. To your knowledge have any unresolved or pending complaints ever been filed against you with any federal or state agency, professional association, licensed hospital or clinic, or staff of such hospital or clinic? | **YES** ☐ **NO** ☐ |
| **6.** Have you ever been arrested, charged or convicted (including a nolo contender plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? **If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities.** | **YES** ☐ **NO** ☐ |
| 7. Currently are you being treated or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice? | **YES** ☐ **NO** ☐ |
| 8. Currently or within the last five years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice? | **YES** ☐ **NO** ☐ |
| 9. Currently or within the last five years, have you developed any disease or conditions, physical, mental, or emotional that might interfere with your ability to competently and safely perform the essential functions of practice? | **YES** ☐ **NO** ☐ |
| 10. a. Have you ever voluntarily surrendered a nursing license?<br>b. Have you ever voluntarily surrendered a controlled substance or DEA registration? | **YES** ☐ **NO** ☐<br>**YES** ☐ **NO** ☐ **NA** ☐ |
| 11. a. Do you plan to prescribe Schedules III through V?<br>b. Do you have a controlled substance or DEA registration? | **YES** ☐ **NO** ☐ **NA** ☐<br>**YES** ☐ **NO** ☐ **NA** ☐ |

## Specialty Area(s) & Certification(s)

1. Specialty area of APRN practice.

2. Describe your specialty area in advanced nursing practice. (This section will be assessed by an Advanced Practice Nursing Consultant who will determine the closest scope of practice area in accordance with National Certification)

3. Do you hold current specialty certification by a national credentialing organization(s)? **YES** ☐ **NO** ☐

   Certifying Organization_______________________________________________

   Expiration date_______________________(Attached a copy of certificate)

## Other

Check here if you are trained and willing to volunteer your services during a bioterrorism disaster? **YES** ☐ **NO** ☐

Check here if you are trained and willing to volunteer your services during a disaster? **YES** ☐ **NO** ☐

Name______________________________
www.llr.state.sc.us/pol/nursing

## Advanced Practice Employment (Current)

<table>
<tr><td rowspan="2">PRIMARY Practice Site<br>(If more than 2 sites, duplicate form as needed)</td><td colspan="3">Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):</td></tr>
<tr><td colspan="3">Practice Address: (Street, City, State, Zip Code)</td></tr>
<tr><td rowspan="2">* Supervising Physician:<br>☐ Primary Physician<br>☐ Alternate Supervising Physician</td><td colspan="2">Supervising Physician (All physicians must have a permanent SC license in good standing)</td><td rowspan="2">Proximity to NP, CNM, CNS in Miles:</td></tr>
<tr><td colspan="2">Business Address: (Street, City, State, Zip)</td></tr>
<tr><td>SC Physician's License No:</td><td>Practice Specialty:</td><td colspan="2">Primary Practice Site Phone Number</td></tr>
<tr><td colspan="4">______________________________ Signature of Supervising Physician *     ____________ Date</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">SECONDARY/ADDITIONAL Practice Site<br>(If more than 2 sites, duplicate form as needed)</td><td colspan="3">Employer Name:</td></tr>
<tr><td colspan="3">Practice Address: (Street, City, State, Zip)</td></tr>
<tr><td rowspan="2">* Supervising Physician:<br>☐ Primary Physician<br>☐ Alternate Supervising Physician</td><td colspan="2">Supervising Physician (All physicians must have a permanent SC license in good standing)</td><td rowspan="2">Proximity to NP, CNM, CNS in Miles:</td></tr>
<tr><td colspan="2">Business Address: (Street, City, State, Zip)</td></tr>
<tr><td>SC Physician's License No:</td><td>Practice Specialty:</td><td colspan="2">Secondary Practice Site Phone Number</td></tr>
<tr><td colspan="4">______________________________ Signature of Supervising Physician *     ____________ Date</td></tr>
<tr><td colspan="4">A copy of practice protocols, for NP, CNM, or CNS/ copy of written approved guidelines for CRNA 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 ☐<br><br>* Note: Pursuant to §40-33-34(H)(2)(a)(ii), in addition to the supervising physician or dentist, CRNAs may also have the physician director of anesthesia services or the medical director of the facility sign this form.</td></tr>
</table>

I, ______________________________________________________________, am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. 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 act shall constitute the cause for denial or revocation of my license to practice in South Carolina.

________________________________________ ____________________________
Signature of applicant (do not print) Date

______________________________________________________________________
Printed name of applicant (first, middle, maiden, last)

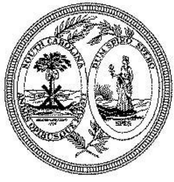
Subscribed and sworn before me this ______________day of _____________________________ , __________

______________________________________ ______________________________________
(Signature of notary public) My commission expires

**Remember to:**

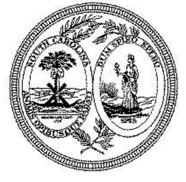
- ☐ Complete and answer all questions; Sign, date and have your application notarized
- ☐ Complete the Affidavit of Eligibility
- ☐ Criminal Background Check (CBC): Board will forward instructions once application is received.
- ☐ Recent 2"x 2" full faced passport type photo, sign and date on front or back and tape along top edge only onto your application
- ☐ Copy of your current state license, other than SC
- ☐ Copy of current specialty certification by a board-approved credentialing organization
- ☐ Copies of legal documents that authorize a change in name, if applicable
- ☐ Obtain all physician signatures and license numbers to be included on your application, if applicable. See the SC Nurse Practice Act for guidelines on the development of written protocols.
- ☐ If applying for Prescriptive Authority, please complete and submit the following: Prescriptive Authority Application and certificates of continuing education hours in pharmacotherapeutics (see statute for specific guidelines).
- ☐ Complete the requirements for the criminal background check
- ☐ Provide proof of residence- copy of driver's license or voter registration card

Once all requirements have been met, your license may be reactivated or reinstated within 10 business days. During peak times, the application review/approval process may take longer.



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

**VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES**
**AFFIDAVIT OF ELIGIBILITY**



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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 __________________

_______________________________

Notary Public for ____________________

My Commission Expires: ____________

I

## 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-688)
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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# APPLICATION FOR PRESCRIPTIVE AUTHORITY

An Nurse Practitioner (NP), Certified Nurse-Midwife (CNM), or Clinical Nurse Specialist (CNS) who applies for prescriptive authority must comply with the following requirements pursuant to: **Section 40-33-34(E)(1) by submitting the following:**

☐ You must have a current NP, CNM or CNS license in this state.

☐ Complete this prescriptive authority application and submit the required $20 fee. You may submit a check or money order in the amount of $20, payable to the SC Board of Nursing. Application fees are non-refundable and non-transferable. A returned check fee of up to $30, or an amount specified by law may be assessed on all returned or insufficient funds.

☐ Provide evidence of completion of **forty-five (45) contact hours of education in pharmacotherapeutics** acceptable to the board, within two (2) years before application **OR** during the time of the organized educational program; **OR shall** provide evidence of prescriptive authority in another state and submit evidence of completion of twenty (20) contact hours **of education in pharmacotherapeutics** acceptable to the board, within the two (2) preceding years before this application;

☐ **IF** the NP, CNM, or CNS has equivalent controlled substance prescribing authority in another state, OR reinstating prescriptive authority in this state, you must provide at least fifteen (15) hours of education **in controlled substances** acceptable to the board as part of the twenty (20) hours required for prescriptive authority.

☐ **IF** the NP, CNM, or CNS initially apply to prescribe in Schedules II through V controlled substances, they must provide at least fifteen (15) hours of education **in controlled substances** acceptable to the board as part of the forty-five (45) contact hours required for prescriptive authority.

☐ A current state-issued license verification or a current DEA registration that reflects current prescriptive authority licensure must be provided with this application. If, however, you were recently licensed as an advanced practice nurse in this state, you may have already submitted this information and will not be required to submit it again.

Applications are reviewed within fourteen (14) business days and if approved, the board shall issue an identification number to the NP, CNM, or CNS authorized to prescribe medications. Approved authorization for prescriptive authority is valid unless terminated by the board for cause. All prescriptive authority authorization expires concurrent with the expiration of the Advanced Practice Registered Nurse license.

**Note:** If you are a new graduate (within the past two years) and proof of contact hours were contained within your official college transcript that was provided with your initial application, you do not need to send in another transcript. IF, however, you have been licensed as an advanced practice nurse for more than two years, the SC State Board of Nursing will accept continuing pharmacotherapeutics / controlled substance prescriptive authority contact hour certificates from approved providers. Visit our website for approved providers at:
https://www.llr.sc.gov/POL/Nursing/PDF/Board_Approved_Listing_for_Pharmacotherapeutics_Education.pdf

## APPLICANT INFORMATION

Last Name: ______________________ First: ____________________ Middle: ____________ Suffix: _______

Mailing Address: ______________________________________________________________________
(Street, City, State, Zip)

Phone: _______________________ Last 5 of SSN: _________________ License No.: _______________
(NP, CNM or CNS)

Email Address: _______________________________________________

Primary Practice/Agency: ______________________________________ Phone: ___________________

Address: ______________________________________________________________________________
(Street, City, State, Zip)

**PRESCRIPTIVE AUTHORITY INFORMATION** Name: ____________________________

1. Do you have an active NP, CNM or CNS license with Prescriptive Authority in another state? ☐ Yes ☐ No

   If **YES**, you will need to provide a copy of your out-of-state DEA registration or a copy of a license verification that shows where you held prescriptive authority.

2. Will you be participating in Telemedicine? ☐ Yes ☐ No

   If **YES**, check all that apply:
   ☐ II Narcotic ☐ II Non-Narcotic ☐ III Narcotic ☐ III Non-Narcotic ☐ IV ☐ V

**PERSONAL HISTORY QUESTIONS**
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.

**Since you were initially licensed or since your last renewal:**

1. Have you been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility, or staff of such facility? ☐ Yes ☐ No

2. Have your privileges been restricted or terminated by any association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures? ☐ Yes ☐ No

3. To your knowledge have any unresolved or pending complaints been filed against you with any federal or state agency, professional association, licensed hospital or clinic, or staff of such hospital or clinic? ☐ Yes ☐ No

4. Have you 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? If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities. ☐ Yes ☐ No

5. Have you been diagnosed and/or been treated for a substance abuse disorder or any physical, mental or emotional condition which in any way currently affects or limits your ability to practice nursing safely and in a competent and professional manner? ☐ Yes ☐ No

6. Are you participating in a substance abuse and/or alcohol, drug treatment, or monitoring program? ☐ Yes ☐ No

We recommend having your supervising physician and written protocol in place before applying. The written protocol does not need to be submitted unless you are audited by the SCBON. The SCBON will notify you in advance if you are being audited.

## PRESCRIPTIVE AUTHORITY
## SUPERVISING PHYSICIAN AND ALTERNATE SUPERVISING PHYSICIAN FORM

**SUPERVISING PHYSICIAN: All physicians must have a permanent SC license which is in good standing.**

SC Medical License No.: ___________________________

Last Name: ________________________________ First: ______________________ Middle: ____________________

Employer Name: ______________________________________________________________________________

Business Address: ____________________________________________________________________________
(Street, City, State, Zip)

Phone: ____________________________________ Practice Specialty: _________________________________

By signing this document, I affirm that I will not enter into practice agreements with more than the equivalent of six full-time NPs, CNMs, or CNSs and must not practice in a situation in which the number of NPs, CNMs, or CNSs providing clinical services with whom the physician is working, combined with the number of physician assistants providing clinical services whom the physician is supervising without prior approval by the SC Board of Medical Examiners, pursuant to **S.C. Code Ann. § 40-47-20(43), 40-47- 195(D)(1)(c).**

__________________________________________________ ____________________________
Signature of Supervising Physician Date

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**ALTERNATE SUPERVISING PHYSICIAN: All physicians must have a permanent SC license which is in good standing. If you have multiple alternate supervising physicians, please attach a list of names and medical license number.**

SC Medical License No.: ___________________________

Last Name: ________________________________ First: ______________________ Middle: ____________________

Employer Name: ______________________________________________________________________________

Business Address: ____________________________________________________________________________
(Street, City, State, Zip)

Phone: ____________________________________ Practice Specialty: _________________________________

By signing this document, I affirm that I will not enter into practice agreements with more than the equivalent of six full-time NPs, CNMs, or CNSs and must not practice in a situation in which the number of NPs, CNMs, or CNSs providing clinical services with whom the physician is working, combined with the number of physician assistants providing clinical services whom the physician is supervising without prior approval by the SC Board of Medical Examiners, pursuant to **S.C. Code Ann. § 40-47-20(43), 40-47- 195(D)(1)(c).**

__________________________________________________ ____________________________
Signature of Supervising Physician Date

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I HEREBY swear/affirm the statements made in this application to be TRUE to the best of my knowledge.
A copy of the signed and dated practice protocols are on file in the office/agency of my employment and will be made available upon request.

_________________________________________________________ ____________________________
Signature of Applicant Date