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) (3) and (H)(4) – 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.

PLEASE DO NOT FAX.

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 SC. CODE SECTION 41-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-196.

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 41-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-196.

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**