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
www.llr.sc.gov/POL/Nursing/

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? 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. ☐ Yes ☐ No
2. Will you be participating in Telemedicine? ☐ Yes ☐ No
3. 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.

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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**