South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
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REQUIREMENTS AND INSTRUCTIONS FOR APRN PRESCRIPTION AUTHORITY APPLICATION

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:

Initial Prescriptive Authority Applicant
After obtaining a SC nurse practitioner, certified nurse mid-wife, or clinical nurse specialist license, a prescriptive authority application may be completed with the following requirement(s):

- Provide evidence of completion of forty-five (45) contact hours of education in pharmacotherapeutics acceptable to the board, within two (2) years before application. At least fifteen (15) of the forty-five (45) hours should be in controlled substances.
    - New graduates (graduated within two (2) years before the application) who have completed a graduate level pharmacology course meet the educational requirements for prescriptive authority and controlled substances.
      Note: If your official college transcript was provided with your initial application, you do not need to send in another transcript.

Endorsement Applicant with Existing Out-of-State Prescriptive Authority
(Has an existing out-of-state prescriptive authority license.)
After obtaining a SC nurse practitioner, certified nurse mid-wife, or clinical nurse specialist license, a prescriptive authority application may be completed with the following requirement(s):

- a current state-issued license verification or a current DEA registration that reflects current prescriptive authority licensure;
- show proof of twenty (20) contact hours in pharmacotherapeutics within two (2) years before application. At least fifteen (15) of the twenty (20) hours should be in controlled substances.

Requirements for Reactivating/Reinstating Prescriptive Authority
- Applicants whose privileges have lapsed for less than six (6) months do not require additional contact hours.
- Applicants whose privileges have lapsed for more than six (6) months or who previously held prescriptive authority in another state whose privileges in that state have expired by more than six (6) months, must meet the requirements of a first time applicant (see Initial prescriptive authority).

Board Approved Listing for Pharmacotherapeutics Education:
https://llr.sc.gov/nurse/PDF/Board_Approved_Listing_for_Pharmacotherapeutics_Education.pdf

APPLICATION FOR PRESCRIPTIVE AUTHORITY

DO NOT FAX OR EMAIL APPLICATIONS – THEY WILL NOT BE PROCESSED.

- Complete this prescriptive authority application and submit with 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.

- Submit supporting documentation as indicated in the Requirements above, if applicable.

Application By:

☐ **Initial Application** ☐ **Endorsement Application**

☐ **Reactivate/Reinstate - Date license inactive/expired:** _____

APPLICANT INFORMATION

Last Name: _____ First: _____ Middle: _____ Suffix: _____

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

Phone: _____ Last 5 of SSN: _____ SC License No.: _____
(NP, CNM or CNS)

Email Address: _____

Primary Practice/Agency: _____ Phone: _____

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

PRESCRIPTIVE AUTHORITY INFORMATION

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

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.

1. **Since you were initially licensed or since your last renewal:** 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. **Since you were initially licensed or since your last renewal:** 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. **Since you were initially licensed or since your last renewal:** 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. **Since you were initially licensed or since your last renewal:** 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? ☐ Yes ☐ No

   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.

5. **Since you were initially licensed or since your last renewal:** 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 collaborating physician and written practice agreement in place before applying. The written practice agreement 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.

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 _____

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.

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**