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
llr.sc.gov/nurse

REQUIREMENTS AND INSTRUCTIONS FOR AN ACTIVE SC RN LICENSEE TO BECOME A SC APRN

REQUIREMENTS

An upgrade applicant for APRN must furnish evidence satisfactory to the Board that the applicant:

- has an active SC RN license in good standing.
- has earned a master's degree from an accredited college.
- has a national certification for the specialty area of nursing practice or the title of the specialty area of nursing practice in which the nurse has received advanced educational preparation.
    - ❖ 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.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS

An applicant for a license to practice nursing in South Carolina shall be subject to a criminal history background check as specified in section 40-33-25 of the Nurse Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received. DO NOT have your fingerprints or CBC report processed until you have submitted an application and received instructions from the Board.

EDUCATION:

Official transcripts from an accredited college or university where the applicant earned a master's degree. Schools for all MSN or Doctorate programs must be approved by either the CCNE or the ACEN.

NATIONAL CERTIFICATION FOR SPECIALTY AREA OF PRACTICE

You must have a national certification for the specialty area of nursing practice. You may include proof of national certification with your application or have it sent directly to the SCBON.

- New graduates shall provide evidence of certification within one year of program completion.
- Psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion.

To see a list of approved certification organizations, please visit this link:
https://www.llr.sc.gov/nurse/PDF/BoardApprovedAdvancedPracticeCertificationOrganizations.pdf

TEMPORARY LICENSE:

You may apply for a sixty (60) day temporary license to practice nursing in SC if one or more of the below listed items is pending for an additional $10 fee. Prescription Authority is only available when a permanent license is issued. A temporary license is not available for applicants who answer yes to the personal history questions related to previous discipline, surrender/relinquishment of a professional license in lieu of discipline, and/or arrest/convictions.

- Criminal background check
- Documentation of your national certification.

SAFEGUARDING PATIENT RECORDS

Each Advanced Practice Registered Nurse (APRN) licensee actively practicing within the State of South Carolina, in a solo practice setting, shall designate a partner, personal representative, or other responsible party to assume responsibility for patient medical records in the case of incapacity, death or disappearance of the licensee, including any circumstances whereby the licensee is unable for any reason to provide continuity of care, appropriate referral or patient medical records upon a valid request of the patient.

Each APRN nurse licensee must identify by name, address, and telephone number their designee required by this regulation upon each application for initial licensure, renewal, and reinstatement.

NOTIFICATION OF INITIAL EMPLOYMENT/CHANGE OF PRACTICE

The South Carolina Nurse Practice Act requires a licensed APRN (NP, CNM, CNS) who changes or discontinues primary practice settings or collaborating physicians to notify the board of this change within 15 business days and provide verification of a written practice agreement. A CRNA who changes or discontinues practice settings or physicians/dentists shall notify the Board of such change within 15 days and provide verification of written guidelines.

PRESCRIPTIVE AUTHORITY APPLICATION

The prescriptive authority application is a separate process from initial licensure. We recommend having your collaborating physician and written protocol in place before applying. The written protocol should not be submitted unless you are audited by the SCBON. Visit https://llr.sc.gov/nurse/Online/APRNRX.aspx for detailed application requirements and instructions.

INSTRUCTIONS

Include with your application:

- Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, may be assessed on all returned funds.
- Copy of your valid driver's license, state issued ID, passport or military ID
- 2" x 2" passport-type photo affidavit form (Must be less than 6 months old.)
- Proof of legal name if it has changed from the name on your RN license (valid passport, marriage certificate, divorce decree, or court order approving a legal name change).
- Copy of current national certification, if applicable
- Malpractice Claim Form, if applicable
- Initial Employment/Change of Practice Form. (If employment is known at the time of application.)
    - APRN Initial Employment/Change of Practice Form
    - CRNA Initial Employment/Change of Practice Form

Have submitted directly to the SCBON from the issuing institution/agency:

- Official transcripts sent from education institution where master's degree was obtained.
- **Criminal Background Check**: Instructions will be sent via email to you **AFTER** your application has been received. Do not have your CBC processed beforehand; it may be purged if your application is not on file, and you will need to pay to have a new one sent.

APPLICATION STATUS

Applications for licensure are valid for one year from the date of filing with the board. An applicant who fails to attain licensure during this period shall submit a new application, application fee, CBC, and required documentation.

Applications are processed (reviewed) in the order they are received. Once they are processed, you will be emailed a status update and instructions on how to have your CBC processed. The email will be sent to the email address you have provided at the time of application. Please check your application status here before calling the Board https://eservice.llr.sc.gov/SSO/ApplicationStatus/Index.

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PASSPORT-TYPE PHOTO AFFIDAVIT FORM

I certify I am the person shown in the photograph below and it has been taken within the last 6 months.

_____
Applicant Signature

_____
Print Applicant Name

Tape Passport Type
Photo Here
2 x 2

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MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

Nurse Name _____ Office Telephone No. _____

Address _____ City _____ State _____ Zip _____

MALPRACTICE COMPLAINT:
Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.

Patient's Name: (Not required) _____

Age: _____ Sex: _____ Date of Occurrence: _____

Place of Occurrence: _____

Indicate your position in case: (i.e., resident, primary physician, etc.) _____

FILED AGAINST: ☐ Individual Nurse ☐ Group ☐ Hospital

List names of other defendant doctors, nurses and/or hospitals:

_____

_____

_____

DISPOSITION: ☐ Pending ☐ Jury Verdict ☐ Settled ☐ Dismissed ☐ Dropped

If the lawsuit against you was dismissed, was it dismissed by the Court on the merits or was it dismissed as a result of settlement negotiations before settlement?

☐ On the merits ☐ Dismissed before settlement

If there has been a verdict or settlement, please provide the following information:

Legal Outcome: _____

Total Amount Paid: (If any) _____ Date Paid: _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Signature: _____ Date: _____

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) – 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.

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 S.C. CODE SECTION 40-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-195.

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 40-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-195.

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**

Advanced Practice Registered Nurse (APRN) – Certified Registered Nurse Anesthetist (CRNA)

Change of Practice Request Form

(§40-33-34 (H)(4) – CRNAs 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.

Last Name	First Name	Middle Name	Maiden Name

Home Address (Street, City, State, Zip):	Home Phone:

Last five of SSN:	SC License #:	Specialty Area:

Nature of Change:

☐ New Employment ☐ Change of Practice Site(s) ☐ Change of Physician/Dentist

☐ Additional Practice Site(s) ☐ Other (specify): _____

☐ Removal of Physician/Dentist 1._____ Lic. #_____ 2._____ 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)
* Supervising Physician/Dentist: (of written guidelines) ☐ Physician ☐ Dentist ☐ Medical Director	Supervising Physician/Dentist of Written Guidelines (Must have a permanent SC license in good standing)
	Business Address: (Street, City, State, Zip)
SC Physician/Dentist's License No:	Primary Practice Site Phone Number

Signature of Supervising Physician/Dentist*: **Date:**

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)
* Supervising Physician/Dentist: (of written guidelines) ☐ Physician ☐ Dentist ☐ Medical	Supervising Physician/Dentist of Written Guidelines (Must have a permanent SC license in good standing)
	Business Address: (Street, City, State, Zip)
SC Physician/Dentist's License No:	Secondary Practice Site Phone Number

Signature of Supervising Physician/Dentist*: **Date:**

A copy of written approved guidelines signed and dated by the physician/dentist 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**