



## 2020-2022 APRN RENEWAL APPLICATION

For online renewal go to <https://eservice.llr.sc.gov/OnlineRenewals/>

**Please check one:**  APRN License  APRN-Rx

### Please read these instructions carefully:

- Renewal fee in the form of a check or money order (no cash) made payable to LLR-Board of Nursing. (All fees are non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.)
- **Fee:** Postmarked 4/30/2020 or before: **\$105** (APRN) or **\$145** (APRN-Rx)
- Your current license, including prescriptive authority, expires at midnight 4/30/2020, and a 2020-2022 license will be required to continue practicing after this time.
- To ensure your licensure renewal application is processed prior to the expiration date, renew online at <https://eservice.llr.sc.gov/OnlineRenewals/> or return your completed form along with proper fees immediately. Answer all questions. Careful completion of this application will avoid a delay in processing. **Incomplete applications will be returned to you.** Please allow 14 business days for processing.

### COLLABORATING PHYSICIAN INFORMATION

Per Section 40-33-34, if your collaborating/supervising physician(s) changed you **MUST** fill out and submit a New Employment/Change of Practice Form to the Board within 15 days of the change. Access the form using one of the links below:

#### New Employment/Change of Practice

APRN Change of Practice form: <https://llr.sc.gov/nurse/pdf/APRNChangePrac.pdf>

CRNA Change of Practice form: <https://llr.sc.gov/nurse/pdf/CRNAChangePrac.pdf>

You can also access the **LICENSEE LOOKUP** (<https://verify.llronline.com/LicLookup/Nurse/Nurse.aspx?div=17>) option on our website to check the collaborating/supervising physician(s) listed on your license.

1. Are you in an APRN role or position that requires a collaborating/supervising physician?  Yes  No

**If Yes**, is the collaborating/supervising physician(s) correct as listed in Licensee Lookup?  Yes  No

**If Yes**, is your collaborating/supervising physician licensed and physically practicing in South Carolina?  Yes  No

The zip code of my primary collaborating physician's practice location is: \_\_\_\_\_

### PRESCRIPTIVE AUTHORITY (If applicable):

Twenty contact hours in pharmacotherapeutics applicable to one's specialty must be obtained between May 1, 2018 and April 30, 2020 and prior to renewing your prescriptive authority. Two of the 20 hours must be related to prescribing controlled substances (refer to statutory language in 40-33-34). APRNs must contact BOTH DHEC and DEA to request Schedule 2/2N controlled substances be added to their registrations.

1. I am renewing Prescriptive Authority:  Yes  No **(Not applicable to CRNA's)**

**If Yes**, have you obtained 20 contact hours in pharmacotherapeutics between May 1, 2018 and April 30, 2020 and prior to renewing your prescriptive authority?  Yes  No

2. Are you prescribing controlled substances?  Yes  No

**If Yes**, of the 20 contact hours in pharmacotherapeutics that you obtained, were 2 hours in controlled substances?  Yes  No

**LICENSEE INFORMATION**

Name: \_\_\_\_\_ License No.: \_\_\_\_\_

If you have a name change, please submit legal documents to [NurseBoard@llr.sc.gov](mailto:NurseBoard@llr.sc.gov).

Home Address: (Physical Location – No PO Box) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ County: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

I declare my primary state of residence is: \_\_\_\_\_ State I plan to primarily practice in is: \_\_\_\_\_

I possess or have possessed a license to practice in the following states:  
\_\_\_\_\_

**EMPLOYMENT INFORMATION**

**Primary Employment and Practice Location**

(Complete statistical information on page 4 using “PRP” column)

Employer Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Practice Location Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Practice County: \_\_\_\_\_ Current hours per week work: \_\_\_\_\_

For statistical purposes only. What percent of your time do you spend rendering Primary Care services at this practice location?  N/A  1 - 10%  11 - 25%  26 - 50%  51 - 75%  76 - 90%  91 - 100%

**Secondary Employment and Practice Location**

(Complete statistical information on page 4 using “SEC” column)

Employer Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Practice Location Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Practice County: \_\_\_\_\_ Current hours per week work: \_\_\_\_\_

For statistical purposes only. What percent of your time do you spend rendering Primary Care services at this practice location?  N/A  1 - 10%  11 - 25%  26 - 50%  51 - 75%  76 - 90%  91 - 100%

**DISCIPLINARY QUESTIONS**

If you answer “Yes” to a question below, a detailed letter of explanation, along with the documentation indicated after each question, must be submitted. If this is your first renewal, answer the questions from the timeframe of since your initial application.

- 1. Since you last renewed your license, have you been convicted, pled guilty or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)?  Yes  No

**If Yes,** attach a brief letter of explanation along with a criminal records check from the state(s) in which you were convicted. Include your name, license number, and daytime telephone number where you can be reached.

- 2. Since you last renewed your license, has your license been suspended or revoked by the SC Board of Nursing or has any other disciplinary action been taken by the SCBON or another state nursing board, in any jurisdiction?  Yes  No

**If Yes,** attach a brief letter of explanation with your name, license number and daytime telephone number where you can be reached. Also, send a request to the board issuing the disciplinary action for a copy of the final Order to be sent directly to the SC Board of Nursing. The Order can also be emailed separately to [NurseRenewal@LLR.sc.gov](mailto:NurseRenewal@LLR.sc.gov) for review.

- 3. Since you last renewed your license, have you received disciplinary action by any employer for your job performance involving patient care or safety?  Yes  No

**If Yes,** attach a brief letter of explanation and any employer documents with your renewal. Include your name, license number and daytime telephone number where you can be reached.

- 4. Since you last renewed your license, have you been treated for and/or diagnosed with 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

**If Yes,** attach a brief letter of explanation. Include your name, license number and daytime telephone number where you can be reached.

- 5. Since you last renewed your license, have you participated in a substance abuse and/or alcohol, drug treatment or monitoring program?  Yes  No

**If Yes,** attach a brief letter of explanation. Include your name, license number and daytime telephone number where you can be reached.

**LAWFUL PRESENCE**

Since you last renewed your license, has there been any change in the status of your lawful presence in the United States (i.e., naturalization, received a renewed permanent resident card, etc.)?  Yes  No

**If Yes,** attach a brief explanation of the change in your eligibility status and any supporting documentation with your renewal.

**ATTESTATION**

I hereby swear/affirm that the statements made on this application to be true to the best of my knowledge.

\_\_\_\_\_  
SC Nursing License No.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**PRIVACY DISCLOSURE**

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.

**FOR RESEARCH AND STATISTICAL PURPOSES**

1. Indicate All Degrees Awarded

Degree Type	Nursing Degrees/Programs			Non-Nursing
	School Name/Program	State	Year	
LPN Program				
Diploma School Nursing				
Associates				<input type="checkbox"/>
Baccalaureate				<input type="checkbox"/>
Masters				<input type="checkbox"/>
Post Masters				<input type="checkbox"/>
Doctorate				<input type="checkbox"/>
Other/Foreign				<input type="checkbox"/>
APRN Certification Prog.				

2. Are you currently in a position that requires a Nursing degree?  No  Yes–Employed  Yes–Volunteer

3. What is your current Employment status? (Select **one** heading and sub-heading)

- a.  **Employed in nursing:** as defined in 40-33-10F: Includes direct patient care, teaching, counseling, administration, research, consultation, supervision, delegation, and practice evaluation.
  - Full-Time in SC  Part-Time in SC  PRN/Per Diem in SC  Out-of-State: (State or Country: \_\_\_\_\_)
  - Other: (Specify) \_\_\_\_\_
- b.  **Employed in non-nursing occupation, seeking nurse employment**
- c.  **Employed in non-nursing occupation, not seeking nurse employment**
- d.  **Unemployed, seeking nursing employment**
- e.  **Unemployed, not seeking employment:**
  - Household Responsibilities  Student  Retired  Other: (Specify) \_\_\_\_\_

**NURSING PRACTICE IN SOUTH CAROLINA:** Indicate **primary employment practice** data in **“PRI”** column, and **Secondary employment practice** data in **“SEC”** column.

4. Please identify the **TYPE(S) OF SETTING(S)** that most closely corresponds with your nursing **PRACTICE** position(s):

<u>PRI</u>	<u>SEC</u>	<u>Description</u>	<u>PRI</u>	<u>SEC</u>	<u>Description</u>
<input type="checkbox"/>	<input type="checkbox"/>	110  Academic Setting (Nurse Practice)	<input type="checkbox"/>	<input type="checkbox"/>	275  Hospital-Surgical Services (IP and OP)
<input type="checkbox"/>	<input type="checkbox"/>	120  Academic Setting (Other)	<input type="checkbox"/>	<input type="checkbox"/>	280  Hospital-Wide (e.g., Admin, Float, IT, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	130  Alcohol/Drug Detox Center	<input type="checkbox"/>	<input type="checkbox"/>	300  Mental Health Center
<input type="checkbox"/>	<input type="checkbox"/>	140  Ambulatory Care Setting (Other not listed)	<input type="checkbox"/>	<input type="checkbox"/>	310  Multi-Setting (Temporary Placement/Telehealth)
<input type="checkbox"/>	<input type="checkbox"/>	150  Ambulatory Surgery Center (Freestanding)	<input type="checkbox"/>	<input type="checkbox"/>	320  NP Provider Clinic (Exclude Retail/In-Store)
<input type="checkbox"/>	<input type="checkbox"/>	160  Assisted Living Facility/Residential Care	<input type="checkbox"/>	<input type="checkbox"/>	330  Nursing Home/Extended Care
<input type="checkbox"/>	<input type="checkbox"/>	170  Community Health (Other not listed)	<input type="checkbox"/>	<input type="checkbox"/>	340  Occupational Health
<input type="checkbox"/>	<input type="checkbox"/>	180  Correctional Facility	<input type="checkbox"/>	<input type="checkbox"/>	350  Physician/Medical Office
<input type="checkbox"/>	<input type="checkbox"/>	190  Dialysis/Infusion Center (Freestanding)	<input type="checkbox"/>	<input type="checkbox"/>	360  Policy/Planning/Reg./Licensing/Advocacy
<input type="checkbox"/>	<input type="checkbox"/>	200  Federal Clinic (FOHC, VA, MIL, NIH, IHS)	<input type="checkbox"/>	<input type="checkbox"/>	370  Public Health Dept. (Treatment Location)
<input type="checkbox"/>	<input type="checkbox"/>	205  Health Industry/Insurance – Support Services	<input type="checkbox"/>	<input type="checkbox"/>	380  Retail/In-Store Clinic
<input type="checkbox"/>	<input type="checkbox"/>	210  Home Care (Incl. in-home hospice and infusion)	<input type="checkbox"/>	<input type="checkbox"/>	390  Rural Health Center
<input type="checkbox"/>	<input type="checkbox"/>	220  Hospice (Inpatient Only)	<input type="checkbox"/>	<input type="checkbox"/>	400  School/College Health Service
<input type="checkbox"/>	<input type="checkbox"/>	230  Hospital – Emergency Room/Department	<input type="checkbox"/>	<input type="checkbox"/>	410  Urgent Care
<input type="checkbox"/>	<input type="checkbox"/>	240  Hospital – Inpatient (General/Acute)	<input type="checkbox"/>	<input type="checkbox"/>	970  Other Patient Care Setting
<input type="checkbox"/>	<input type="checkbox"/>	250  Hospital – Inpatient (ICU, CCU, NICU, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	990  Other:
<input type="checkbox"/>	<input type="checkbox"/>	260  Hospital – Outpatient			(PRI) _____
<input type="checkbox"/>	<input type="checkbox"/>	270  Hospital – Subacute/LTAC/Rehab			(SEC) _____

**FOR RESEARCH AND STATISTICAL PURPOSES**

5. Please identify the employment **SPECIALTY(IES)/AREA(S)** that most closely corresponds with your nursing **PRACTICE** position(s):

<u>PRI</u>	<u>SEC</u>	<u>Description</u>	<u>PRI</u>	<u>SEC</u>	<u>Description</u>
<input type="checkbox"/>	<input type="checkbox"/>	110  Acute Care	<input type="checkbox"/>	<input type="checkbox"/>	290  Maternal-Child Health
<input type="checkbox"/>	<input type="checkbox"/>	120  Administration	<input type="checkbox"/>	<input type="checkbox"/>	300  Medical Surgical Specialties
<input type="checkbox"/>	<input type="checkbox"/>	130  Adult Health/Family Health	<input type="checkbox"/>	<input type="checkbox"/>	310  Neonatal
<input type="checkbox"/>	<input type="checkbox"/>	141  Analytics/Research	<input type="checkbox"/>	<input type="checkbox"/>	320  Occupational Health
<input type="checkbox"/>	<input type="checkbox"/>	150  Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	330  Oncology
<input type="checkbox"/>	<input type="checkbox"/>	160  Cardiac Care	<input type="checkbox"/>	<input type="checkbox"/>	335  Outcomes/Quality/Documentation Review
<input type="checkbox"/>	<input type="checkbox"/>	170  Case Management	<input type="checkbox"/>	<input type="checkbox"/>	340  Palliative Care/Pain Management
<input type="checkbox"/>	<input type="checkbox"/>	180  Community Health	<input type="checkbox"/>	<input type="checkbox"/>	350  Pediatrics
<input type="checkbox"/>	<input type="checkbox"/>	190  Critical Care	<input type="checkbox"/>	<input type="checkbox"/>	360  Peri/Post/Pre-Operative
<input type="checkbox"/>	<input type="checkbox"/>	200  Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	370  Professional Development
<input type="checkbox"/>	<input type="checkbox"/>	210  Dialysis/Nephrology	<input type="checkbox"/>	<input type="checkbox"/>	380  Psychiatric/Mental Health/Substance Abuse
<input type="checkbox"/>	<input type="checkbox"/>	220  Emergency/Traumas	<input type="checkbox"/>	<input type="checkbox"/>	390  Public Health
<input type="checkbox"/>	<input type="checkbox"/>	230  Faith Based/Congregational/Parish Nurse	<input type="checkbox"/>	<input type="checkbox"/>	400  Rehabilitation
<input type="checkbox"/>	<input type="checkbox"/>	240  Forensic/SANE	<input type="checkbox"/>	<input type="checkbox"/>	410  School Health
<input type="checkbox"/>	<input type="checkbox"/>	250  General Nursing Practice	<input type="checkbox"/>	<input type="checkbox"/>	420  Women's Health
<input type="checkbox"/>	<input type="checkbox"/>	260  Geriatric/Gerontology	<input type="checkbox"/>	<input type="checkbox"/>	430  Wound/Ostomy/Continence
<input type="checkbox"/>	<input type="checkbox"/>	270  Hospice	<input type="checkbox"/>	<input type="checkbox"/>	990  Other:
<input type="checkbox"/>	<input type="checkbox"/>	280  Informatics			(PRI) _____
					(SEC) _____

6. Please identify the **JOB TITLE(S)** that most closely correspond with your nursing **PRACTICE** position(s):

- (PRI):  CNM  CNS  CRNA  NP  RN  
 (SEC):  CNM  CNS  CRNA  NP  RN

7. Please identify the **POSITION TITLE(S)** that most closely corresponds with your nursing **PRACTICE** position(s):

<u>PRI</u>	<u>SEC</u>	<u>Description</u>	<u>PRI</u>	<u>SEC</u>	<u>Description</u>
<input type="checkbox"/>	<input type="checkbox"/>	110  APRN Credential Required – CNM	<input type="checkbox"/>	<input type="checkbox"/>	230  Patient Educator
<input type="checkbox"/>	<input type="checkbox"/>	120  APRN Credential Required – CNS	<input type="checkbox"/>	<input type="checkbox"/>	240  Quality/Utilization Review (Incl. Accreditation)
<input type="checkbox"/>	<input type="checkbox"/>	130  APRN Credential Required – CRNA	<input type="checkbox"/>	<input type="checkbox"/>	250  School Nurse
<input type="checkbox"/>	<input type="checkbox"/>	140  APRN Credential Required – NP	<input type="checkbox"/>	<input type="checkbox"/>	260  Staff Nurse/Direct Care/General Duty Nurse
<input type="checkbox"/>	<input type="checkbox"/>	150  Care Coordinator/Case Mgr./Discharge Planner	<input type="checkbox"/>	<input type="checkbox"/>	270  Supplemental Staffing/Travel/VNS Nurse
<input type="checkbox"/>	<input type="checkbox"/>	155  Charge Nurse/Supervisor	<input type="checkbox"/>	<input type="checkbox"/>	280  Telehealth Nurse
<input type="checkbox"/>	<input type="checkbox"/>	160  Consultant (e.g., Legal, Edu., Prac. Standards)	<input type="checkbox"/>	<input type="checkbox"/>	290  Triage/Advice Nurse
<input type="checkbox"/>	<input type="checkbox"/>	170  Faculty/Professor	<input type="checkbox"/>	<input type="checkbox"/>	960  Other – Health Related (Org/Operations Focus)
<input type="checkbox"/>	<input type="checkbox"/>	180  Information Nurse/Informaticist	<input type="checkbox"/>	<input type="checkbox"/>	970  Other – Health Related (Patient Focus)
<input type="checkbox"/>	<input type="checkbox"/>	190  Nurse Educator (Incl. In-Service, Prof. Dev.)	<input type="checkbox"/>	<input type="checkbox"/>	980  Other – Non-Health Related:
<input type="checkbox"/>	<input type="checkbox"/>	200  Nurse Executive/Administration			(PRI) _____
<input type="checkbox"/>	<input type="checkbox"/>	210  Nurse Manager			(SEC) _____
<input type="checkbox"/>	<input type="checkbox"/>	220  Nurse Researcher			