



South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
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 llr.sc.gov/nurse

2020-2022 RN/LPN RENEWAL APPLICATION

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

Please check one: RN License LPN License

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: **\$75 (RN) or \$75 (LPN)**
- Your current license 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.

LICENSEE INFORMATION

Name: _____ License No.: _____

If you have a name change, please submit legal documents to 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 currently practice in the following states: _____

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

Demonstration of Continued Competency: Renewal of an active license biennially requires documented evidence of ONE of the following requirements completed **prior** to renewing your license. **DO NOT SEND ANY CONTINUED COMPETENCY PAPERWORK WITH YOUR RENEWAL.** The Board will randomly select licensees to be audited. If you are chosen for the audit, you will be notified in writing by the Board and at that time will be required to submit this information within five (5) days of the request.

I swear or affirm that I have completed and have documentation for at least one of the following competency requirements between May 1, 2018 and April 30, 2020 and prior to this renewal.

Yes No

- Completion of thirty contact hours from a continuing education provider recognized by the board during 05/01/18 - 4/30/20; **OR**
- Maintenance of certification or re-certification by a national certifying body recognized by the board; **OR**
- Completion of an academic program of study in nursing or a related field recognized by the board; **OR**
- Verification of competency and the number of hours practiced, as evidenced by employer certification on a board approved form.

EMPLOYMENT INFORMATION

Primary Employment and Practice Location

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

Employer Name: _____ Phone No.: _____

Practice Location Address: _____

City: _____ State: _____ Zip: _____

Practice County: _____ Current hours per week work: _____

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: _____

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 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) _____

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			