South Carolina Department of Labor, Licensing and Regulatio
Board of Podiatry Examiners
Synergy Business Park, Kingstree Building
110 Centerview Drive, Suite 202
Post Office Box 11289
Columbia, SC 29211-1289
(803) 896-4500

REACTIVATION APPLICATION

Complete all sections of this application by providing all of the requested information. You must notify the Board in writing within fifteen (15) business days of any address changes after you file this application in order to receive information from the Board. This application form is a public document obtainable under the Freedom of Information Act.

SC License Number_____

PART I: Applicant Identifying Information

1. **Last Name**	2. **First Name**	3. **Middle Name**	4. **Suffix (Jr., III)**

5. **Title** ☐DPM	6. **Maiden Name**	7. **Social Security Number/Alien ID***

8. **Mailing Address** (Street or PO Box, City, State, Zip)

9. **Home Address** (Street, City, State, Zip – not PO Box)	9a. **Home Congressional District**

9b. **Home Phone**	9c. **Home Fax**	9d. **Home Email**

10. **Business Name**	10a. **Business Address** (Street, City, State, Zip – not PO Box)

10b. **Business Phone**	10c. **Business Fax**	10d. **Business Email**

11. **Place of Birth** (List City & State or Country)	12. **Date of Birth** MM/DD/YYYY	13. **Gender**	14. **Race (For Statistical Purposes Only)**
		☐ Male ☐ Female	☐ African American/Black ☐ American Indian ☐ Asian/Oriental ☐ Hispanic/Spanish Origin ☐ Caucasian/White ☐ Other

PART II: Education Information

SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		

Professional Education

List in chronological order from date of graduation to the present all professional education. Do not include continuing education coursework, apprenticeship, intern, residency, vocational training practical or clinical training.

INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM	DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

PART III: Record of Licensure

Complete the requested information below if you have ever been licensed to practice in any profession or occupation. You must identify the method by which you obtained your license(s). You must include jurisdiction both within and outside the United States. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

Jurisdiction	Credential Type	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date of Initial Issuance
State or Country of Original (Initial) Licensure:				
State or Country of Current licensure where you most recently practiced:				
List Other Jurisdictions of Licensure:				

PART IV: Employment History

List all related employment chronologically most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable in Box 1. You are authorized to photocopy this form if additional space is required.

1. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** **From:** _____ **To:** _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
2. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** **From:** _____ **To:** _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
3. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** **From:** _____ **To:** _____

Part V: Personal History Information

If you answer "yes" to any of the questions below (1-15), you must attach a full written explanation pertaining to that particular question.

1. Has your podiatry license ever been revoked, suspended, reprimanded, restricted or placed on probation by a podiatry licensing board or other entity?	**YES** ☐ **NO** ☐
2. Have you ever had an application to practice podiatry denied or refused by another podiatry licensing board or other entity?	**YES** ☐ **NO** ☐
3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way?	**YES** ☐ **NO** ☐
4. Have you ever voluntarily surrendered a podiatry license, controlled substance registration or DEA registration?	**YES** ☐ **NO** ☐
5. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action?	**YES** ☐ **NO** ☐
6. Are you currently under investigation or the subject of pending disciplinary action by any podiatry licensing board, health care facility or other entity?	**YES** ☐ **NO** ☐
7. Is your podiatry license currently restricted in any way or have you ever been fined by any podiatry licensing board, or other entity?	**YES** ☐ **NO** ☐
8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If so, how many? _____ (Complete the attached malpractice form, if applicable)	**YES** ☐ **NO** ☐
9. Currently or within the last ten years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
10. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
11. Has your ability to practice podiatry ever been impaired by any physical or mental illness or by the use of alcohol or drugs?	**YES** ☐ **NO** ☐
12. Have you ever discontinued the practice of medicine for any reason for one month or more?	**YES** ☐ **NO** ☐
13. Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity?	**YES** ☐ **NO** ☐
14. Currently or within the last ten years, have you been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)?	**YES** ☐ **NO** ☐
15. Have you ever been known by any other name or surname?	**YES** ☐ **NO** ☐

For Board Member use only

_____ _____

Applicant Signature Date

_____ _____

Board Member Signature Date

PART VI: Certifying Statement

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Podiatry Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Podiatry Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Podiatry Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Podiatry Boards' Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

_____
Signature of Applicant (Do not print)

_____
Printed Name of Applicant

_____
Date

Subscribed and sworn to before me this _____ day of

_____, _____.

_____
Notary Public

My Commission Expires: _____

Attach professional photo here

(2x2)
Passport size

No copies

Do Not Staple

For Office Use Only

Date Received: _____

Paid by: ☐ Check ☐ Money Order

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

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Reactivation Requirements

A person with an inactive license to practice podiatry in this State who wishes to resume active practice shall submit an application for reactivation including:

1. Completed **application** (Copies not accepted);

2. **Fee** - Non-refundable application fee of $75.00 is required with your application. Application will not be processed without the required $75.00 application fee. Make check payable to **LLR-Board of Podiatry Examiners.** No cash, credit cards or debit cards accepted**;**

3. Attached a professional 2x2 **photo** - no copies;

4. Submit copies of 24 hours of **continuing medical education**; (See attached 40-51-140)

5. **Malpractice form** - If applicable, complete and return the enclosed malpractice form with the requested information to the board if you have ever been named in a malpractice suit or settlement;

6. **Verification of licensure** – A verification form is enclosed and may be duplicated as needed. This board must receive a verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice medicine; and

7. A licensee shall notify the board in writing within fifteen (15) business days of any change of residential address, office address, or office telephone number. Please mail or fax change of address information to the board or logon to www.llr.state.sc.us/pol/Podiatry and report your change of address information to the board.

8. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Application will be processed within 14 business days of the received date and you will be notified of any deficiencies in your file.

9. It is a violation of state law if a podiatrist practices podiatry before being issued a license. Violators are subject to fines and possible criminal prosecution.

10. Please visit the board website at www.llr.state.sc.us/pol/Podiatry to review the South Carolina Podiatry Practice Act.

11. Documented evidence of continuing medical education through a program approved by the Board is required for renewal of a permanent license. (See 40-51-140 of the Podiatry Practice Act)

Visit the Board's webpage at www.llr.state.sc.us/pol/podiatry

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VERIFICATION OF PODIATRY LICENSE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever been licensed to practice podiatry. You may want to check with each state board to ask if a fee is required.

In applying for a license to practice Podiatry in the State of South Carolina, the Board of Podiatry Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise regarding myself, directly to the above address:

Please type or print

Signature _____

Name _____

Address _____

_____
City State Zip

DO NOT DETACH

_____

This section should be complete by an official of the state board and returned directly to the Board of Podiatry Examiners.

Full name of licensee: _____

Graduate of: _____Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Licensed by: ( ) National Board ( ) PMLexis Exam

( ) State Board Exam ( ) Other _____

License is current? _____ If no, why not? _____

Has license been suspended, revoked, or restricted? _____ If yes, why? _____

Comments, if any _____

Date: _____ Signature: _____

Title: _____

BOARD SEAL

State Board: _____

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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.

_____

Podiatrist 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: _____

Age: _____ Sex: _____

Date/place of occurrence: _____

Indicate your position in case, i.e., resident, primary podiatrist etc.; _____

_____

_____

FILED AGAINST: ( ) Individual Doctor ( ) Group ( ) Hospital
List names of other defendant-doctors and/or hospitals:

_____

_____

DISPOSTION: ( ) Pending ( ) Jury Verdict ( ) Settled ( ) Dismissed/Dropped ( ) Dropped
If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ Total amt. paid (if any): _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and 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.

Date _____ Signature _____