South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
110 Centerview Dr • Columbia • SC• 29210
P.O. Box 11289 • Columbia • SC• 29211
Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515
www.llronline.com/POL/Medical/

Instruction Cover Sheet for Additional Task Request Form for Physician Assistants application

- Please complete application in its entirety including patient chart record retention for **5-5-5.** Include patient charting information for each task. **(see example of patient charting below)**

- If you have proof of competence from prior employment (old patient records) meeting the **5-5-5** basic requirement, and a letter from a prior supervising physician documenting your performance as adequate to add to your application.

- If you are adding additional alternate physicians with this request, the alternate physician ***may not*** begin serving as an alternate supervisor until he/she has been approved by the Board. The physician must hold a permanent, unrestricted South Carolina license.

- To check the status of any application approval, visit the agency website **www.llronline.com, Online Services, Licensee Lookup, select Medical/Physician Assistant/Respiratory Care.** If your application has not been processed, and it has been **more than 15 business days** contact the board **(803) 896-4500.**

- If the primary supervising physician leaves the practice, the Physician Assistant **(PA) must stop working** until he/she has written approval **(Change/Additional Primary Supervisor Form for Physician Assistants application)** from the Board for another physician to serve as his/her supervising physician. An alternate supervising physician ***may not*** assume this role without approval from the Board.

- If primary or alternate primary supervisors are listed that require termination, complete **Primary Supervisor Termination Notification application** from **Licensure Application and Forms for Physician Assistants,** or contact the board providing **Physician Assistant name and license number, primary supervising physician name and license number, and the name of the alternate supervisor(s) for the board to process your request.**

Example of patient charting to be submitted with PA Additional Task Request

Observed 5 times	Dosing	Outcome	Complication
1) Patient Chart Number and Date			
2) Patient Chart Number and Date			
3) Patient Chart Number and Date			
4) Patient Chart Number and Date			
5) Patient Chart Number and Date			
Assist 5 times	**Dosing**	**Outcome**	**Complication**
1) Patient Chart Number and Date			
2) Patient Chart Number and Date			
3) Patient Chart Number and Date			
4) Patient Chart Number and Date			
5) Patient Chart Number and Date			
Perform 5 times	**Dosing**	**Outcome**	**Complication**
1) Patient Chart Number and Date			
2) Patient Chart Number and Date			
3) Patient Chart Number and Date			
4) Patient Chart Number and Date			
5) Patient Chart Number and Date			

S.C. Department of Labor, Licensing and Regulation
Board of Medical Examiners
P.O. Box 11289
Columbia, SC 29211-1289
(803) 896-4500
(803) 896-4515 (fax)

ADDITIONAL TASK REQUEST FORM

Pursuant to Section 40-47-938, A supervising physician may determine that there are additional medical acts, tasks, or functions for which a physician assistant under the physician's supervision needs additional training or education to meet the needs of the physician's practice and that the physician would like to incorporate into the physician assistant's scope of practice guidelines. The physician must notify the Board in writing of the requested changes to the physician assistant's scope of practice guidelines and must provide documentation to the Board of the competence of the physician assistant to perform the additional medical acts, tasks, or functions. Upon receipt of Board approval of the requested changes, the physician assistant may incorporate these additional medical acts, tasks, or functions into practice. **Please complete one form per additional act, task, or function that you are requesting to add to your scope of practice guidelines.**

Physician Assistant's Name: _____

Supervising Physician's Name: _____

SPECIFIC TASK REQUESTED: _____

1. Number of times performed under direct supervision:_____
2 Length of time performed (days, weeks, months): _____
3. Written prior experience and any formal training for this task: _____

_____

_____

_____

4. Statement from supervising physician that he/she is satisfied with the Physician Assistant's demonstrated competence to perform this task:

_____

_____

_____

_____	_____	_____
Supervising Physician's Signature	SC License No.	Date
_____	_____	_____
Physician Assistant's Signature	PA License No.	Date
_____	_____	
Board/Committee Member's Signature	Date Approved	

Please complete this form and return to the South Carolina Medical Board at the address listed above.