South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Podiatry Examiners

110 Centerview Dr. • Columbia • SC • 29210

P.O. Box 11289 • Columbia • SC 29211-1289

Phone: 803-896-4500 • MedBoard@llr.sc.gov• Fax: 803-896-4515 www.llronline.com/POL/Podiatry/

INSTRUCTIONS AND REQUIREMENTS FOR LICENSURE AS A PODIATRIST

REQUIREMENTS

EDUCATION:

- Completed at least three (3) years of pre-podiatry training at recognized college.
- Received a diploma or certificate of graduation from a recognized college of podiatry medicine, which has been accredited by the Council on Podiatric Medical Education.

EXAMS:

- **Parts I, II, & III of the National Board of Podiatry Examiners**

"Part I, II & III (PMLexis) and Disciplinary reports should be ordered directly from the Federation of Podiatric Medical Boards via their online system at https://www.fpmb.org. Payment can be made with a credit card. Alternatively, online orders can be printed and mailed to the FPMB with a check."

In addition to submitting or providing for submission of the documents as listed in the application package, an applicant must also pass Part III of the National Board of Podiatry Examiners (*formerly PMLexis*). The PMLexis examination is administered in June and December. Only applicants for licensure in South Carolina may take the PMLexis examination. Please advise the Board if you plan to sit for the PMLexis in South Carolina.

If applying as a podiatrist who performs osseous (boney) surgical procedures of the ankle and related soft tissue structures governing the ankle, you must submit:
1) copy of board certification or board qualification by the American Board of Foot and Ankle Surgery; and
2) certification of graduation from a three-year residency program in podiatric medicine and reconstructive rear foot and ankle (RRA) surgery accredited by the Council on Podiatric Medical Education.

Controlled Substance Registration

Application for both federal and state registration are available from the Narcotic and Drug Control Division, Dept. of Health and Environmental control, 2600 Bull Street, Columbia, SC 29201, (803) 896-0634.

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Application for a License to Practice Podiatry

Include with your application:

- Check or money order in the amount of $500 made payable to LLR-Board of Podiatry Examiners 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
- Copy of your social security card
- A 2"x2" professional photo that is notarized (Passport Photo)
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable
- APMA Certification, if applicable
- Certification of graduation from a 3 year residency in podiatric medicine and reconstructive rear foot and ankle surgery (RRA), if applicable
- Original, certified copy of your birth certificate
- Preceptorship or residency certificate (one year completed)

Have submitted directly to the Board office address above from the issuing agent:

- License Verification from each state podiatry board that you are currently or have ever been licensed in.
- 3 Letters of Recommendation from Podiatrists that know you on a professional basis
- Parts I & II of National Boards
- PMLexis Examination
- Certification of Podiatry Education (form enclosed) and Official Transcript
- Undergraduate college transcript

Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

I. APPLICANT INFORMATION:

Last Name:____________________First:______________________Middle:_________________Suffix:________

Have you ever legally changed your name? ☐ Yes ☐ No Maiden Name: ______________________________

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: __________________________City:____________State:______Zip:__________District:_____

Congressional District (SC Residents Only)

Mailing Address: _____________________________________City:_______________State:_____Zip:_______

(If different than above)

Phone: ___________________________ Email Address: ____

Business Name: ____ Phone: __________________________

Fax: _____________________________ Email Address: ____

Date of Birth: _____________________ Social Security No.: ____________________________________

Place of Birth (City, State or Country): ____

Race: ____________________________ Gender: ☐ Female ☐ Male

(For statistical purposes only)

Name: ______________________________

II. PROFESSIONAL EDUCATION INFORMATION

List in chronological order from date of graduation all professional education. Do not include continuing education coursework, apprentice, internship, residency, vocational training practical or clinical training. Attach additional sheet(s) if needed.

Institution/Program	LOCATION (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Graduation/Program Completed?	Degree Earned

III. INTERSHIP AND RESIDENCY TRAINING INFORMATION

Complete the requested information below on all training programs completed in the US or Canada. Failure to disclose any training program information may result in the denial of your application or other appropriate action. Attach an additional sheet if necessary.

School Name	LOCATION (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Did you complete program?

IV. RECORD OF EXAMINATION

Complete the requested information below if licensure examination was taken in this state or any other state.

Name of Examination	LOCATION (State or Country)	Date of Exam	Passed/Failed Score

V. RECORD OF LICENSURE

List all states in which you have been licensed in for any medical profession; regardless of status: Active, Inactive, Expired, Training etc. You will need to contact each State Board and request a License Verification to be mailed directly to the Medical Board at the above listed address. We provide a License Verification Form as a courtesy; however, we will accept a state board issued form. Attach additional sheet if needed.

State/Jurisdiction	License No.	State/Jurisdiction	License No.	State/Jurisdiction	License No.

VI. PODIATRY SPECIALTY AND SC LOCATION INFORMATION

1. What is your current podiatry specialty? ______________________________

2. **Proposed South Carolina Location Information** (If known)**:**
   Name of Hospital/Clinic: ______________________________

   Complete Address: ______________________________

3. **Are you APMA Board certified/recertified? (**If yes, attach a copy of the certificate) ☐ YES ☐ NO
   If yes, date you were certified/recertified: ______________________

4. Are you board certified or board qualified by the American Board of Foot and Ankle Surgery? (If yes, attach a copy of the certificate)
   ☐ YES ☐ NO

5. Have you completed a three year residency in podiatric medicine and reconstructive rear foot and ankle (RRA) surgery? (If yes, attach a copy of the certificate)
   ☐ YES ☐ NO

VII. PODIATRY PRACTICE EMPLOYMENT HISTORY

List all related employment (not training or residency) 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. Attach an additional sheet if needed.

FROM Month / Yr	**TO Month / Yr**	**EMPLOYER NAME**	**OFFICE ADDRESS**	**TYPE OF PRACTICE**

Name: ______________________________

VIII. PERSONAL HISTORY INFORMATION

If you answer yes to any of the below questions, you must attach a full written explanation.

1. Has your podiatry license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a podiatric licensing board or other entity?

☐ YES ☐ NO

2. Have you ever had an application to practice podiatry denied or refused by another medical licensing board or other entity?

☐ YES ☐ NO

3. Have you ever had any hospital or health care facility privileges denied, revoked, suspended or restricted in any way?

☐ YES ☐ NO

4. Have you ever voluntarily surrendered a medical 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. Have you ever had a malpractice lawsuit, judgment filed against you or settled a medical malpractice claim? If yes, how many? _________
(Complete a Malpractice Information Claim Form for each claim)

☐ YES ☐ NO

8. Are you currently being treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a podiatrist?

☐ YES ☐ NO

9. Do you currently have any mental illness (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) or any physical illness or condition that might interfere with your ability to competently and safely perform the essential functions of practice?

☐ YES ☐ NO

10. Within the past two (2) years, has your ability to practice podiatry been impaired by any physical or mental illness or by the use of alcohol and/or drugs?

☐ YES ☐ NO

11. Have you ever discontinued the practice of podiatry for any reason for three consecutive months or more?

☐ YES ☐ NO

12. Was your medical education / residency training interrupted other than for vacation periods or military service?

☐ 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. Within the last ten (10) years, have you ever been convicted, pled guilty or pled *nolo contendere* to a felony of any kind or to a non-felony crime involving drugs, fraud, deception, sexual misconduct, gross immortality or unauthorized practice of podiatry?

☐ YES ☐ NO

IX. LETTERS OF RECOMMENDATION

Please supply below names and addresses of three podiatrists willing to write letters of recommendation to support your application for South Carolina medical licensure. **You must request that each podiatrist listed below write directly to the Board** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina. The letters must be signed by the physician writing on your behalf. Make note of the reference number and podiatrist's name listed for when you check your application status later.

Reference 1.

Name: ____ Phone: ____________________

Address: ____

Street, City, State, Zip

Reference 2.

Name: ____ Phone: ____________________

Address: ____

Street, City, State, Zip

Reference 3.

Name: ____ Phone: ____________________

Address: ____

Street, City, State, Zip

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

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.

X. CERTIFYING STATEMENT

I, ____ being duly sworn, depose and say that I am the person described and identified, 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 podiatry 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 agents or representatives 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 podiatry in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

____
Signature of Applicant

____
Print Name of Applicant

Subscribed and sworn to before me this ______ day

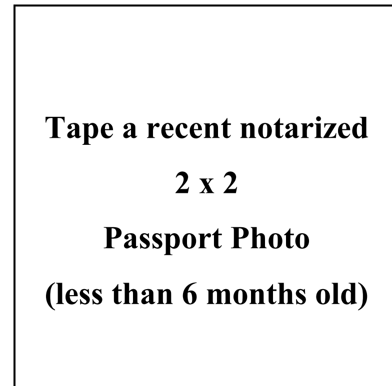
of ________________20________.

Notary Signature: _________________________________

Print Name: ______________________________________

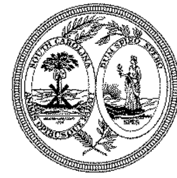
Notary for the State of: ____________________________

My Commission expires: ___________________________



(Notary Seal)

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned ______________________________________, of______________________________________
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other:_____________________Please submit any documentation that supports this status.

Date of Birth: ___________________

Alien Number:_____________________ I-94 Number: __________________

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

____
Signature of Affiant

SWORN to before me this________day of_____________________, 20_______

____
Notary Signature

____
Print Name

Notary Public for ____

My Commission Expires: ___________________________________

Rev: 02-02-2015

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)

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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.

____ _________________________

Physician 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 of Occurrence: ________________________________

Place of Occurrence: ____

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

FILED AGAINST: ( ) Individual Doctor ( ) Group ( ) Hospital

List names of other defendant-doctors and/or hospitals:

____

____

____

DISPOSITION: ( ) Pending ( ) Jury Verdict ( ) Settled ( ) Dismissed ( ) Dropped

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.

Date: _________________________ Signature: ____

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VERIFICATION OF LICENSURE

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

In applying for a license to practice medicine in the State of South Carolina, the Board of Medical 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 me directly to the above address.

PLEASE TYPE OR PRINT

Signature: ______________________________

Name: ______________________________

Address: ______________________________

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: ______________________________

Graduate of: ______________________________ Date of degree: ______________________________

State of: ______________ License number: ______________________ Date issued: ______________________

Licensed by: ( ) National Board ( ) FLEX Exam ( ) USMLE ( ) State Board Exam ( ) Other: ______________

Is license current ☐ Yes ☐ No If no, why not? ______________________________

Has license been suspended, revoked, or restricted? ☐ Yes ☐ No If yes, why? ______________________________

Comments, if any: ______________________________

____

Date: ______________________________ Signature: ______________________________

Print name: ______________________________

Board Seal Title: ______________________________

Board: ______________________________