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

SUMMARY OF REQUIREMENTS FOR A LICENSE TO PRACTICE

You must follow these instructions to obtain a permanent license to practice as a physician assistant in SC. An applicant shall comply with the following requirements as outlined in Section 40-47-945 of the Physician Assistant Practice Act.

A. LICENSURE REQUIREMENTS

An individual shall obtain a permanent license from the board before the individual may practice as a physician assistant. The board shall grant a permanent license as a physician assistant to an applicant who has:

1. submited a completed application on forms provided by the Board;
2. pay the non-refundable application fee;
3. successful completion of an educational program for physician assistants approved by the Commission on accredited Allied Health Education Programs or its successor organization;
4. successful completion of the NCCPA certifying examination and provide documentation that he or she possesses a current, active, NCCPA Certificate;
5. certification that he or she is mentally and physically able to engage safely in practice as a physician Assistant;
6. no licensure will be provided as a physician assistant under current discipline: , revocation, suspension, probation, or investigation for cause resulting from the applicant's practice as a physician assistant;
7. good moral character;
8. submit to the Board any other information the Board considers necessary to evaluate the applicant's qualifications;
9. appear before a Board member or designee with all original diplomas and certificates and demonstrated knowledge of the contents of this article;
10. successfully completed an examination administered on the statutes and regulations regarding physician assistant practice and supervision; and
11. Scope of practice guidelines must accompany the application.

B. CRIMINAL BACKFROUND CHECK- See enclosed procedures

C. REQUIRED SOUTH CAROLINA EXAMINATION

Applicants who have never been permanently licensed in South Carolina must take an examination on the statutes and regulations regarding physician assistant's practice and supervision. Applicants who fail this examination must retake and pass the exam before being assigned for an interview with a Board representative.

D. PHYSICIAN SUPERVISORS/SUPERVISING PHYSICIAN

The supervising physician is responsible for all aspects of the physician assistant's practice. The supervising physician shall identify the physician assistant's scope of practice and determine the delegation of medical tasks. Supervision must be continuous but must not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where the services are rendered, except as otherwise required for limited licensees. A supervising physician may not supervise more than three physician assistants. Only physicians with permanent unrestricted South Carolina licenses may serve as supervising physicians. A physician who is on probation with this Board may not serve as a primary or alternate supervising physician.

E. ALTERNATE SUPERVISING PHYSICIANS

Alternate supervising physicians are responsible for the physician assistant in the absence of the primary supervising physician. Only physicians with permanent South Carolina licenses may serve as alternate supervising physicians. A physician who is on probation with this Board may not serve as an alternate supervising physician. The application must include the signature(s) of alternate supervisor(s). To add an alternate supervising physician at a later time, the physician assistant must complete the Adding Alternate Physicians Form.

F. CHANGE OF SUPERVISING PHYSICIAN

The Change/Additional Primary Supervisor form must be submitted when changing or adding an additional primary supervisor. A signed copy of the scope of practice guidelines must accompany this form.

G. TERMINATION OF SUPERVISORY RELATIONSHIP

If the supervisory relationship between a physician assistant and the supervising physician is terminated for any reason, the physician assistant and supervising physician shall inform the Board immediately in writing of the termination, including the reasons for the termination. The approval of the practice setting terminates coterminous with the termination of the relationship, and practice shall cease until new scope of practice guidelines are submitted by a supervising physician and is approved by the Board.

H. SCOPE OF PRACTICE GUIDELINES

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervising physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. Sample scope of practice guidelines are available on the board website. The guidelines shall include at a minimum the:

a) name, license number, and practice addresses of all supervising physicians;
b) name and practice address of the physician assistant;
c) date the guidelines were developed and dates they were reviewed and amended;
d) medical conditions for which therapies may be initiated, continued, or modified;
e) treatments that may be initiated, continued and modified;
f) drug therapy, if any, that may be prescribed within the usual scope of the supervising physician's practice; and
g) situations that require direct evaluation by or immediate referral to the physician, including Schedule II controlled substance prescription authorization as provided for in Section 40-47-965.

I. TEMPORARY LICENSE

A temporary license, under certain circumstances, may be issued to applicants who meet all requirements for a permanent license and have filed a completed application. However, a "yes" response to questions on the application may require an appearance before the full committee/board before a temporary license can be issued.

J. INTERVIEW REQUIREMENT

An interview with an individual board member or board designee is required before a permanent license can be issued. When your application is complete and a temporary license issued, you will be sent information about the interview along with setting up the interview with a board member or board designee. Once approved for permanent licensure you may apply for prescriptive authority. (Insert 6)

K. INSTRUCTIONS AND INFORMATION

1. Allow 15 business days for processing before contacting the board regarding the status of your application.

2. **Fee -** A non-refundable application fee of $120.00 is required with your application. Application will not be processed without the required $120.00 application fee. Make check payable to **LLR-Board of Medical Examiners**.

3. **Prescriptive Authority application fee** is $40.00 and must accompany the prescriptive authority application (Insert 4). Only physician assistants with permanent licenses are eligible for prescriptive authority.

4. Application documentation - The application form is self-explanatory. It sets forth the required information that must be submitted with your application. An application will be considered incomplete until the following is furnished:

A) Completed application;
B) Certification of physician assistant education (Insert 1) – Complete and mail to your PA program;
C) Verification of license/certificates (Insert 2) - Verification form may be duplicated as needed;
D) A copy of your current NCCPA Certificate;
E) Three letters of recommendations;
F) South Carolina Physician Assistant Examination (Insert 3);
G) Malpractice form completed, if applicable (Insert 5);
H) Criminal Background Check

5. Controlled substance registration – Complete the controlled substance prescriptive authority form and submit proof of completion of 15 hours in controlled substance education. Applications 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. Applicants who possess permanent licenses may apply for a controlled substance registration.

6. It is a violation of the medical practice act to practice as a physician assistant before being licensed by this board. Violators will be subject to substantial penalties**.**

7. A supervising physician may not supervise more than three physician assistants.

8. A physician assistant must clearly identify himself or herself as a physician assistant to ensure that the physician assistant is not mistaken or misrepresented as a physician. A physician assistant shall wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the physician assistant's name and the words 'Physician Assistant'.

You may check the status of your application by visiting the website at www.llronline.com/pol/medical

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Criminal Background Check (CBC)

Effective May 1, 2008, an applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in 40-47-36 of the Medical Practice Act.

This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI). The cost of conducting a criminal history background check is $55.00. Make checks payable to Morphotrust USA.

To schedule an appointment online with Morphotrust USA, please visit www.identogo.com or call 1-866-254-2366 for assistance in scheduling your CBC.

South Carolina applicants will need to show one (1) form of identification - South Carolina State Issued Photo Drivers License.

For out of state applicants who do not hold a South Carolina State Issued Photo Drivers license, you will need to submit two (2) forms of identification from the list below:

State issued photo Drivers License
Social Security Card
Passport
Birth Certificate
Marriage License

If you are a non-resident of South Carolina and reside in an area where no Morphotrust USA fingerprinting centers are available, please follow the Non-Resident Card Scan Processing Procedures on the next page. Click here or visit webpage www.identogo.com to see if your state has Morphotrust USA fingerprinting centers.

Do not return fingerprint card or fingerprint processing fee to the Board.

ORI # SC920110Z

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Non-Resident Card Scan Processing Procedures

Applicants who reside in an area where no Morphotrust USA fingerprinting centers are available may use Morphotrust USA Card Scan Processing Program. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. Converting a "hard card" into an electronic record enables an applicant to have their fingerprint record processed as quickly as if they had traveled to an electronic fingerprint processing location. The section below details the procedures for submitting fingerprints to the Card Scan Processing Unit.

South Carolina Licensing and Certification

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards.
- Fingerprints may be submitted on FBI applicant cards.
- FBI applicant cards are available from the state agency requiring you to be fingerprinted (i.e. Department of Education, Insurance, Labor, Licensing, and Regulation, etc.). Please contact those licensing and certifying agencies directly to obtain fingerprint cards. *Due to agency specific information, Morphotrust USA does not provide fingerprint cards to applicants*.
- Applicants need to make sure the fingerprint cards are completely filled out. Required information includes: ORI number, full name, social security number, date of birth, home address, sex, height, weight, hair color, eye color, place of birth (state or country only), citizenship, and reason fingerprinted.
- The ORI number and Reason Fingerprinted that must be used for on the fingerprint card should be provided by the licensing or certifying agency. **ORI # SC920110Z**
- **Failure to completely fill out the information on the fingerprint card will result in the card being returned to the applicant, which will delay the licensing process**.
- The fully completed card, along with the appropriate fee (indicated in the application packet) should then be mailed to the following address:

Morphotrust USA
Attn: SC Card Scan Department
3051 Hollis Drive Suite 310
Springfield, IL 62704

Please include a daytime telephone number where the applicant can be reached in case there are questions about the fingerprint card.

- Please include the full name of the applicant on each check or money order.
- ***Do not send completed certification or licensing applications to Morphotrust USA***; these documents should be returned to the state agency that will be issuing the license.
- Applicants wishing to verify that a fingerprint card has been processed may call 866-254-2366 and speak with a customer service representative.

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

APPLICATION FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

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.

PART I: Applicant Identifying Information

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

5. **Title** Mr. ☐ Mrs. ☐ Ms. ☐	6. **Maiden Name**

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 ☐ Hispanic/Spanish Origin ☐ American Indian ☐ Caucasian/White ☐ Asian/Oriental ☐ 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. (Revised 7/10/12)

Was your education interrupted other than for vacation periods? If yes, attach a written explanation.	**YES** ☐ **NO** ☐

Branch of military service_____ date of service _____

type of discharge (attach a copy) _____

NCCPA Certificate Number_____ Expiration date_____
Attach a copy)

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) and include jurisdiction both within and outside the United States current or inactive. 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 (PA)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date issued
State of Original (Initial) Licensure:				
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. Photocopy this page and attach 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: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
4. 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**
5. 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**

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 physician assistant certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity?	**YES** ☐ **NO** ☐
2. Have you ever had an application to practice as a physician assistant denied or refused by another 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 resigned from any hospital, institution or health care facility in lieu of disciplinary action?	**YES** ☐ **NO** ☐
5. Have you ever voluntarily surrendered a physician assistant license/certificate, controlled substance registration or DEA registration?	**YES** ☐ **NO** ☐
6. Are you currently under investigation or the subject of pending disciplinary action by any licensing board, health care facility or other entity?	**YES** ☐ **NO** ☐
7. Is your physician assistant license/certificate currently restricted in any way by any licensing board, health care facility or other entity?	**YES** ☐ **NO** ☐
8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If yes, 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 as a physician assistant?	**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 as a physician assistant?	**YES** ☐ **NO** ☐
11. Has your ability to practice as a physician assistant ever been impaired by any physical or mental illness or by the use of alcohol or drugs?	**YES** ☐ **NO** ☐
12. Have you ever discontinued practicing as a physician assistant 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. Have you ever 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: Notification of Initial Employment

(This form is to be completed by Supervising Physician)

This form is not required for the issuance of a license but must be received by the Medical Board before employment begins.

1. **Last Name**	2. **First Name**	3. **Middle Name**	4. **Suffix (Jr., III)**
5. **Title** M.D.☐ D.O.☐	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. SC License Number_____ Type of Practice_____

12. List any certification by ABMS/AOA approved specialty board(s): _____

13. List name and location of any hospital or other offices (other than your own) where you request this Physician assistant to assist you:

Hospital/Office	Location
_____	_____
_____	_____
_____	_____

14. Scope of Practice Guidelines must accompany this form. These guidelines must be practice specific and clearly specify in detail those tasks for which approval is being sought.

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervisory physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. The guidelines shall include at a minimum the:

a) name, license number, and practice addresses of all supervising physicians;
b) name and practice address of the physician assistant;
c) date the guidelines were developed and dates they were reviewed and amended;
d) medical conditions for which therapies may be initiated, continued, or modified;
e) treatments that may be initiated, continued and modified;
f) drug therapy, if any, that may be prescribed within the usual scope of the supervising physician's practice; and
g) situations that require direct evaluation by or immediate referral to the physician, including Schedule II controlled substance prescription authorization as provided for in Section 40-47-965.

PART VII: Notification of Initial Employment

This form is not required for the issuance of a license but must be received by the Medical Board before employment begins. This form must accompany Part VI: Notification of Initial Employment

I hereby certify that the foregoing is correct and true, and I assume responsibility for supervising all tasks performed by my physician assistant under my supervision. It is my responsibility to inform all approved alternate supervising physicians of the responsibilities of supervising my physician assistant.

Primary Supervising Physician Signature	S.C. License No.	Printed Name	Date
Alternate Supervising Physician Signature	S.C. License No.	Printed Name	Date
Alternate Supervising Physician Signature	S.C. License No.	Printed Name	Date
Alternate Supervising Physician Signature	S.C. License No.	Printed Name	Date
Alternate Supervising Physician Signature	S.C. License No.	Printed Name	Date
Alternate Supervising Physician Signature	S.C. License No.	Printed Name	Date
Alternate Supervising Physician Signature	S.C. License No.	Printed Name	Date

(Attach an additional sheet, if needed.)

PART VIII: Letters of Recommendation

Please list below names and addresses of three individuals willing to write letters of recommendation to support your application for physician assistant licensure in South Carolina. Two letters must be from physicians and the third may be from a physician assistant familiar with your work**. You must request that these individuals write directly to this Board (on letterhead)** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for Physician assistant licensure in South Carolina. **Your application will not be considered complete until letters of reference from three individuals below and all other materials necessary to support your application have been received.**

1. Name _____telephone ( )_____

   Address_____City, State, Zip _____

2. Name _____telephone ( )_____

   Address_____City, State, Zip _____

3. Name _____telephone ( )_____

   Address_____City, State, Zip _____

PART IX: 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 as a physician assistant 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 Medical 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 Medical 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 as a physician assistant 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 Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician 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 Signature

My Commission Expires: _____

Attach passport photo here

(2x2)
Passport size

No copies

Do Not Staple

For Office Use Only

Date Received: _____

Paid by: ☐ Check ☐ Money Order ☐ Cash

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this Affidavit of Eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check the acceptable secure and verifiable document(s) you hold. A copy of the verifiable document(s) must be attached to the Affidavit of Eligibility.

☐ A valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card. Number _____; Date of Expiration: _____

☐ A valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit. State: _____; Number_____; Date of Expiration: _____.

☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.

☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____

☐ Certificate of Naturalization with intact photo.

☐ Certificate of (US) Citizenship with intact photo.

☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where the secure and verifiable document(s) was issued.

_____

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____
(Include a copy of the card with the Affidavit)

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and 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 Date

_____

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The 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.

South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive
P.O. Box 11289
Columbia, South Carolina 29211
(803) 896-4500

Applicant's Name_____ _____
First Middle Last

I am applying for a license to practice as a physician assistant in South Carolina. Please complete this form bearing the institution's official seal to the address above.

_____ _____
Applicant's Signature Date

CERTIFICATION OF PHYSICIAN ASSISTANT EDUCATION

It is hereby certified that _____

of (home town, state and country) _____

attended (full name of program) _____

from _____ to _____ and received a diploma

conferring the degree of _____ and said diploma bears

the following date _____.

(Seal)

_____
(Dean, Registrar, P.A. Program Director)

Current Date _____

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Physician Assistant 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 been licensed/certified to practice as a physician assist. 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 _____

_____

City State Zip

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: _____

License is current_____ If no, why not? _____

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

Comments, if any_____

_____

Date: _____ Signature: _____

Board Seal Title: _____

State Board: _____

South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110Centerview Drive, P.O. Box 11289
Columbia, South Carolina 29211
(803) 896-4500

PHYSICIAN ASSISTANT STATE EXAM

This exam is considered part of the application process and must be returned to the Board along with the application. Please answer "true or false". Visit our website at www.llr.state.sc.us/pol/medical for a copy of the South Carolina Physician Assistant Practice Act.

True or False

1. The Physician Assistant Committee is made up of seven Physician Assistants to serve as an advisory committee to the State Board of Medical Examiners. _____
2. Physician Assistants in South Carolina are no longer certified; they are now licensed. _____
3. Physician Assistants in South Carolina are allowed to sign for and dispense pharmaceutical samples including Class II through IV controlled substances. _____
4. A Physician Assistants license must be renewed every other year on or before January first. _____
5. After a Physician Assistant is approved for a temporary license, the Committee will meet and issue a permanent license, extend the temporary license, or withdraw the temporary license. _____
6. Physician Supervisor means a South Carolina licensed physician currently possessing an active unrestricted permanent license to practice medicine in South Carolina who is approved to supervise no more than three Physician Assistants. _____
7. Current NCCPA Certification is not required to obtain a permanent license to practice as a Physician Assistant in South Carolina. _____
8. A Physician Assistant may not practice at any location more than sixty miles of travel time from the Supervising Physician without written approval of the Board. _____
9. A Physician Assistant may not perform a task which has not been listed and approved on the scope of practice guidelines on file with the Board. _____
10. If the supervisory relationship between the Physician Assistant and the Supervising Physician is terminated for any reason, the Board must be notified within six months. _____
11. All tasks of the Physician Assistant are identified in the scope of practice guidelines. _____
12. Prescriptive Authority is not needed to request, receive or sign for professional samples. _____
13. "Supervising" means overseeing the activities of, and accepting responsibility for the medical services rendered by a Physician Assistant as part of a physician-led team in a manner approved by the board. _____
14. A Physician Assistant may not perform any task that is outside the usual scope of the Supervising Physician's practice. _____
15. In the event of the termination of the employment agreement between the Physician Assistant and the primary Supervising Physician, the Alternate Supervising Physician may assume the responsibility. _____

_____ _____ _____
Physician Assistant Signature Print Name Date

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APPLICATION FOR PRESCRIPTIVE AUTHORITY

PHYSICIAN ASSISTANT NAME:_____

I acknowledge, understand, and assume my responsibilities as supervising physician of the above named Physician Assistant for prescriptive authority. I understand that should a Physician Assistant acting under my supervision engage in illegal conduct, I shall be subject to discipline under the Medical Practice Act. I further understand and agree that if the Physician Assistant engages in any unprofessional, unethical or illegal conduct, that I will promptly report such action in writing to the State Board of Medical Examiners of South Carolina.

If the Physician Assistant wishes to prescribe Schedule II-V drugs (as authorized in section 40-47-965), an application for a Controlled Substances registration must be obtained from DHEC-Division of Narcotic and Drug Control for a controlled substance license at (803) 896-0634.

_____ _____
Supervising Physician Signature **Date**

_____ _____
Physician Assistant Signature **Date**

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BOARD APPROVAL:

PRESCRIPTIVE AUTHORITY NUMBER:_____

APPROVED BY BOARD:_____**DATE:**_____

Prescriptive Authority fee: $40

CONTROL #_____

CHECK #_____

AMOUNT $_____

South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
P.O. Box 11289 • Columbia, SC 29211
Phone: 803-896-4500 • Fax: 803-896-4515 • www.llronline.com/POL/Medical

Controlled Substance Prescriptive Authority Form

Pursuant to Section 40-47-965 (B) of the 1976 Code of Laws, amended, this is to confirm under oath and penalty of law that I have completed the requirements of the South Carolina Board of Medical Examiners regarding the authorization of licensed Physician Assistants in South Carolina to prescribe Controlled Substances in Schedules II-V.

I hereby certify that I am duly licensed in South Carolina as a Physician Assistant based upon current certification by the NCCPA, which includes not less than 60 contact hours of pharmacotherapeutics. I further certify that I have **successfully completed at least 15 contact hours of education in controlled substances acceptable to the Board.** (Documentation of controlled substance education must accompany this form).

I further certify that my scope of practice guidelines include prescribing controlled substances in Schedules II-V (as authorized in section 40-47-965), as approved by my Supervising Physician.

This form shall serve as an addendum to my approved scope of practice guidelines on file with the Board. It is further understood that I must register with DHEC-Drug Control and have a valid DEA number before prescribing any controlled substances.

_____	_____
Physician Assistant (Signature)	Physician Assistant (Print Name)
_____	_____
Supervising Physician (Signature)	Supervising Physician (Print Name)

(Only this form is to be completed and returned to the Board office. Pages 2-4 of this document are to be kept on file at each practice site.)

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This Document must be signed by the Physician Assistant and Supervising Physician stating they have read and understand the expanded prescribing privilege for Physician Assistants in South Carolina. A copy must be kept on file at each practice site. It must be reviewed biennially to ensure proper prescribing procedures are followed.

TO: All South Carolina Licensed Physician Assistants and Supervising Physicians

RE: Management of Expanded Prescriptive Authority for Physician Assistants in South Carolina

The following information was developed to help licensed Physician Assistants in South Carolina in their practice of prescribing controlled substances. You must maintain a copy of this document at all practice sites for inspection upon request by the Board of Medical Examiners or its agent. New rules effective March 15, 2006, give Physician Assistants the ability to prescribe controlled substances upon obtaining a DEA number, registering with the South Carolina Department of Health and Environmental Control's Bureau of Drug Control and signing, with their primary supervising physician, the following document approved by the Board. Spaces are provided at the end of this document for your convenience in fulfilling that responsibility.

Management of Controlled Substances Prescriptive Authority for Physician Assistants in South Carolina

The South Carolina Board of Medical Examiners is charged by law to regulate properly the practice of medicine and surgery for the benefit and protection of the people of the State. Many prescribers are asked to appear before the Board because of a lack of information about the management and responsibilities involved in prescribing controlled substances. The typical inadvertent offender is likely to be a prescriber with a sincere attitude and a desire to relieve pain and misery, but who is also pressed for time and prescribes controlled drugs at patient demand over prolonged periods without adequate documentation. Problem prescriptions are often for chronic ailments such as headache, arthritis, vague old injuries, chronic orthopedic problems, backache or anxiety. (Terminal cancer pain management is not a consideration here.)

It is not what you prescribe; rather it is how well you manage the patient's care and document the treatment in legible form. Prescribing matters which come before the Board are almost always related to controlled substances. A majority of instances where licensees have been disciplined by the Board for prescribing practices could have been avoided completely if the steps outlined here were followed.

The Board does not have a list of **"bad" or "disallowed"** drugs. Any drug approved by your supervising physician may be prescribed and administered when properly indicated and, conversely, may be harmful or even lethal when used inappropriately. There is no magic formula for determining the dosage and duration of administration for any drug. Prescribing must be determined within the confines of the individual case and continued under proper monitoring. What is good for one patient may be insufficient or fatal for another. The Board expects licensees to create a record that shows:

- Proper indication and route for the use of drug or other therapy;
- The dosage and volume prescribed (including any refills);
- Monitoring of the patient when necessary or appropriate;
- The patient's response to therapy on follow-up visits;
- Rationale for continuing or modifying the therapy.

STEP ONE - Document an Adequate Examination: First and foremost, before you prescribe anything, start with a diagnosis which is supported by the history and physical findings of the patient being treated and by the results of any appropriate tests. Too many times a licensee must be asked why a particular drug was prescribed. An example of a typical response is, "Because the patient has arthritis." The licensee is asked, "How was that diagnosis reached?" and may answer, "Because that's what the patient complained of." In this example nothing in the record or in the licensee's recollection supports the diagnosis except the patient's assertion. **Do a workup sufficient to support your diagnosis,** including all the necessary studies and/or references to appropriately support the patient's diagnosis.

STEP TWO - Establish a Treatment Plan: Create a treatment plan, which includes the use of non-addictive modalities, if appropriate. Make referrals where appropriate and when included as a part of your written instruction. If referrals are made, the findings of the consultant should be included in the patient's chart.

STEP THREE - Try Conservative Modalities: Before beginning a regimen of addictive or dependence-producing drugs, make a determination through trial or a documented history of a trial that non-addictive modalities are not effective. A finding of intolerance or allergy to non-steroidal anti-inflammatory drugs is one thing, but the assertion of the patient that, "nothing seems to work like that Percodan stuff," is quite another. Many of the practitioners the Board has seen have started a treatment program with powerful controlled substances and did not consider other options or forms of treatment. This may be appropriate in acute settings.

STEP FOUR - Watch out for Drug Seekers: Be wary of the patient who, without adequate clinical symptoms, requests narcotic pain relief. Be alert also to the patient who lists multiple narcotic pain medications to which the requester has allegedly developed allergies and then names another which is well-tolerated. If you know the patient, review the prescription records in the patient's chart and discuss whether the patient has a history of chemical dependency before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum, obtain a verbal drug history, and discuss narcotic or chemical use and family chemical abuse history with the patient. Checking with pharmacies and pharmacy chains may tell you whether a patient is obtaining extra drugs or is prescription shopping.

STEP FIVE - Patient Education: As with any treatment, educate the patient before using a drug that has the potential to cause dependency problems. Take the time to explain the relative risks and benefits of the drug.

STEP SIX - Know the Patient's Environment: The family is a good source of information on behavioral changes, especially dysfunctional behavior. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be symptoms of dependency or addiction. The family is also a good source of information on whether the patient is obtaining drugs from other sources or is self-medicating with other drugs or alcohol.

STEP SEVEN - Monitor the Patient: Maintain regular contact with the patient, including physical monitors. If the regimen is for prolonged narcotic use, a referral for a second opinion may be helpful. It is very important to monitor the patient for the status of the underlying disease, which necessitated the drug and for the potential side effects of the drug itself. This is true no matter what type of controlled substance is used or on what schedule it is listed. With certain conditions and certain drugs, a drug holiday may be appropriate. This could allow you to check the original symptoms during a time when the drug is not given, indicating continuing need for the drug or signaling that the duration of therapy has met its goal and that the medication may be discontinued.

STEP EIGHT - Control the Supply: Make sure you are in control of the supply of the drug. To do this, you must keep detailed records of the type, dose and amount of the drug prescribed. Some practitioners issue only written prescriptions and use multiple copy scripts or photocopies. You must also monitor, record and personally control refills. Do not authorize your office personnel to refill prescriptions. One good way to accomplish this is to require the patient to return to obtain refill authorization. Records of cumulative authorized dosing and average daily dosage can be valuable.

STEP NINE - Maintain Detailed Patient Records: It cannot be emphasized enough that one of the most frequent problems faced by a practitioner when the licensee comes before the Board or other outside review bodies is inadequate records. It is entirely possible that the practitioner did everything correctly in managing a case. Your medical records should be legible and understandable so that any outside reviewer can understand the process which you have followed to manage each patient.

_____ _____

Physician Assistant Signature **Date**

_____ _____

Supervising Physician Signature **Date**

The Physician Assistant and Supervising Physician reviewed the preceding document on the following dates:

Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
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Telephone (803) 896-4500

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 Assistant 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 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: _____

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

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: _____