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/

REQUIREMENTS FOR LIMITED LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

An applicant for limited licensure in South Carolina must comply with Section 40-47-950.

(A) The Board may issue a limited physician assistant license to an applicant who has:

(1) submitted a completed application on forms provided by the Board;
(2) paid the non-refundable application fee;
(3) successfully completed an educational program for physician assistants approved by the American Medical Association Counsel on Medical Education; (Insert 3)
(4) never previously failed two consecutive NCCPA certifying examinations and has registered for, or intends to register to take the next offering of, the NCCPA examinations; (Insert 2)
(5) certified that he or she is mentally a physically able to engage safely in practice as a physician assistant;
(6) no licensure, certificate, or registration 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) submitted to the Board any other information the Board considers necessary to evaluate the applicant's qualifications;
(9) appeared before a Board member designee with his or he supervising physician and all original diplomas and certificates and demonstrated knowledge of the contents of this article;
(10) successfully completed an examination on the statutes and regulations regarding physician assistant practice and supervision. (Insert 5)
(11) scope of practice guidelines must accompany the application.
(12) Criminal Background Check (CBC)

(B) A limited license is not renewable and is valid only until the results of a limited licensee's two consecutive NCCPA certifying examinations are reported to the board. When a limited licensee has failed two consecutive NCCPA certifying examinations, or fails one exam and does not take the NCCPA certifying examination at the next opportunity or, after applying for a limited license, fails to register for the next offering of the examination, the limited license is immediately void and the applicant is no longer eligible to apply for further limited licensure. (Insert 2)

(C) A licensee who supervises another practitioner shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of their respective profession or shall hold an active unrestricted academic license to practice medicine in this State. The supervising physician of a limited licensee must be physically present on the premises at all times when the limited licensee is performing any task. No on-the-job training, or task not listed on the application, may be approved for a limited license holder.

(D) A licensee who supervises another practitioner shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of their respective profession or shall hold an active unrestricted academic license to practice medicine in this State. Alternate supervising physicians are responsible for the physician assistant in the absence of the primary supervising physician. The application must include the signature(s) of alternate supervisor(s). **To add an alternate supervising physician at a later time, the alternate(s) must write this Board requesting to be added**. This request must include the original signature and SC permanent license number. The alternate(s) will be notified in writing of approval and may not begin serving as an alternate until he/she has received written approval from the Board.

(F) A prescriptive authority form is included in this packet and may be submitted along with the $40 RX Authority Application Fee; however, Limited PA license holders are not eligible for prescriptive authority until they have received a permanent license.

(G) Upon successful passage of the NCCPA examination, you may update to a permanent license by submitting a copy of your NCCPA certificate and an update fee of $120. Prescriptive Authority Application forms are on the Board's website at www.llr.state.sc.us/POL/medical.

Include with your application:

- Check or money order made payable to LLR-Board of Medical 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.
  $25 for application fee **OR $65** ($25 application fee and $40 Prescriptive Authority application fee)
- Agreement signed by Physician Assistant and Supervising Physician
- Copy of your valid Driver License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable
- Application for non-controlled substance prescriptive authority, if applicable
- Controlled Substance Prescriptive Authority Form, if applicable
- Notification of Initial Employment with:
  Cover Sheet for Scope of Practice
  Supervision Statement initialed by PA
  Copy of the applicable Scope of Practice:
  (http://www.llronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM)

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

- Certification of Education Form or Official Transcripts
- License Verification from each state medical board that you are currently or have ever been licensed in.
- Criminal Background Check (CBC)
- **Copy of your current letter of eligibility sent directly to the Board from the NCCPA regarding your eligibility to sit for the next available NCCPA examination (www.nccpa.net)**

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Limited License Application to Practice as a Physician Assistant

Include with your application:

- Check or money order made payable to LLR-Board of Medical 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.
  Indicate which one:
  $25 for application fee **OR** **$65** ($25 application fee and $40 Prescriptive Authority application fee)
- Agreement signed by Physician Assistant and Supervising Physician
- Copy of your valid Driver License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable
- Application for non-controlled substance prescriptive authority, if applicable
- Controlled Substance Prescriptive Authority Form, if applicable
- Notification of Initial Employment with:
  Cover Sheet for Scope of Practice
  Supervision Statement initialed by PA
  Copy of the applicable Scope of Practice:
  (http://www.llronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM)

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

- Certification of Education Form or Official Transcripts
- License Verification from each state medical board that you are currently or have ever been licensed in.
- Criminal Background Check (CBC)
- **Copy of your current letter of eligibility sent directly to the Board from the NCCPA regarding your eligibility to sit for the next available NCCPA examination (www.nccpa.net)**

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 college 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. 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.

IV. MEDICAL PRACTICE EMPLOYMENT HISTORY

List all medically 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: ______________________________

PERSONAL HISTORY INFORMATION

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

1. Has your physician assistant license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by any licensing board or other entity? YES NO

2. Have you ever had an application to practice as a physician assistant denied or refused by another medical 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 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 medical 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 physician assistant? 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 as a physician assistant? YES NO

10. Within the past two (2) years, has your ability to practice medicine 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 practicing as a physician assistant 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. 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 or moral turpitude? YES NO

VI. 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 as a physician's 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 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 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's assistant in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

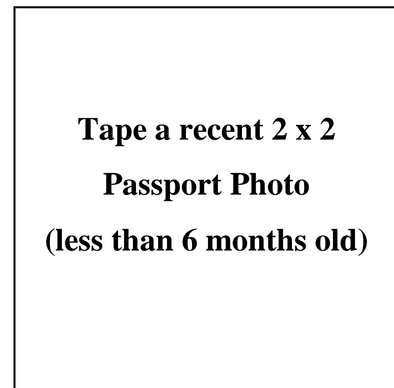
I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities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

____
Signature of Applicant

____
Print Name of Applicant

Subscribed and sworn to before me this ______ day

of _______________20_______.



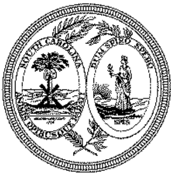
Notary Signature: ________________________________

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: __________________________

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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Notification of Initial Employment

Scope of Practice Guidelines: The guidelines must be practice specific and clearly specify in detail those tasks for which approval is being sought. Board approved scope of practices may be found at:
http://www.llronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM

Attach with this form the following (These forms are found on the above listed website):

- Cover Sheet for Scope of Practice
- Supervision Statement initialed by PA
- Copy of applicable scope of practice

PHYSICIAN ASSISTANT:

Last Name:____________________Suffix:___________First:__________________Middle:_________________

PRIMARY PHYSICIAN INFORMATION:

Title: ☐ M.D. ☐ D.O. SC License Number: ____________________________

Last Name:____________________Suffix:___________First:__________________Middle:_________________

Business Name: ____ Phone: __________________________

Business Address: _____________________________________City:_______________State:____Zip:_______

Fax: _____________________________ Email Address: ____

SPECIALTY INFORMATION:

List any certification by ABMS/AOA approved specialty board(s): _____________________________________

LOCATION INFORMATION:

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:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

SCOPE OF PRACTICE:

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.

Physician Assistant Name: ___________________________

Please note:
Section 40-47-955(D)(E): A supervising physician may not supervise more than three (3) full-time equivalent physician assistants.

The supervising physician has the option to remove an existing physician assistant or submit a letter to the Board indicating that no more than three (3) full-time equivalent physician assistants will work together at any given time.

If the primary supervising physician leaves the practice, the PA must stop working until he/she has written approval 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.

CERTIFYING STATEMENT

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
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.)

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Scope Cover Sheet

http://llronline.com/POL/Medical/index.asp?file=PAScopeApproval.HTM

For scope of practice approval, please submit the following:

- Scope Cover Sheet;
- Supervision Statement initialed by the PA; and
- the applicable scope of practice.

You do not have to include in your specific scope any tasks listed on the *Tasks All SC-Licensed PAs May Perform* document. If you choose to select the standard board-approved scope without additions or modifications, your scope can be approved administratively without board review.

SCOPE OF PRACTICE TYPE : ____

Date Submitted: __________________

Please select one: Standard Board-approved Scope with no modifications

Please see changes as noted on form

	Name	**License #**
Physician Assistant:	______________________________	________________________
Supervising Physician:	______________________________	________________________

Practice Site Address: ____

Phone: ________________________

Additional practice sites [if any]: ____

____

____
Physician Assistant Signature

____
Supervising Physician Signature

____
Alternate Supervising Physician

PA Committee Use Only:

*Reviewed by:*______________________________________ *Date:* _________________________

______ *APPROVED* ______ *APPROVED[AS AMENDED]* ______ *NOT APPROVED*

Supervision Statement

The supervising physician bears the ultimate professional and legal responsibility for the practice and conduct of the physician assistant, (the PA).

Upon licensure and board scope of practice approval, supervising physicians, alternate supervising physicians and physician assistants acknowledge their understanding of all aspects of the statutes, regulations and policies pertaining to practice with or as a physician assistant.

The supervising physician and the physician assistant must practice above all in accordance with the South Carolina Medical Practice Act and Regulations of the South Carolina Medical Board as well as other federal and state laws.

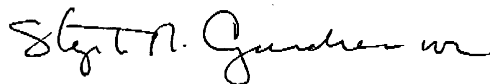
The South Carolina medical practice act and the approved scope of practice are the foundation for safe practice using physician assistants. All medical tasks, procedures and prescribing must be within the approved scope of practice as individually approved by the board.

Changes to the medical practice act affecting the practice of physician assistants and their supervising physicians were enacted in May 2013. Regardless of the employment arrangement, management style or employer policies, it is the fundamental responsibility of the individual licensees involved to become thoroughly familiar with these changes as well as the practice act in its entirety to ensure public protection and avoid individual disciplinary action.

What constitutes legally compliant physician supervision depends upon several factors: The content of the physician assistant's approved scope of practice; the physician assistant's level of prescriptive authority if any, the training, experience and education of the physician assistant, the number of physician assistants supervised, the amount of time the supervising physician and the physician assistant have worked together, the distance between the supervising physician and the physician assistant if authorized by the board for off-site practice, the practice setting and the medical specialty.

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".

Any questions concerning the requirements of the Physician Assistants practice act should be addressed prior to undertaking any action.



Dr. Stephen R. Gardner
President, S.C. Board of Medical Examiners

Physician Assistant initial_____

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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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APPLICATION FOR PRESCRIPTIVE AUTHORITY (NON-CONTROLLED SUBSTANCES ONLY)

Include one-time $40 application fee

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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Controlled Substance Prescriptive Authority Form

Controlled Substances Prescriptive Authority: Submit the Controlled Substance Prescriptive Authority Form along with a copy of the certificate showing successful completion of the course: Continuing Medical Education for Appropriate Prescribing of Controlled Substances for Physician Assistants [15 hours of Category I CME credits].

Controlled Substance Registration –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. You cannot register with the DHEC Bureau of Drug Control until you have received your Expanded Authorization to Prescribe Schedule Controlled Substances Approval Letter from the S.C. Board of Medical Examiners office.

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)	Supervising Physician (Signature)
______________________	______________________
Physician Assistant (Print Name)	Supervising Physician (Print Name)
______________________	______________________
Date	Date

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 • Medboard@llr.sc.gov • Fax: 803-896-4515

www.llronline.com/POL/Medical/

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. It is not necessary to send this form back to the Medical Board.

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)	Supervising Physician (Signature)
______________________________	______________________________
Physician Assistant (Print Name)	Supervising Physician (Print Name)
______________________________	______________________________
Date	Date

Biennial Review Record

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

Date	Physician Assistant Signature	Supervising Physician Signature
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Date	**Physician Assistant Signature**	**Supervising Physician Signature**
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Date	**Physician Assistant Signature**	**Supervising Physician Signature**

STATE BOARD OF MEDICAL EXAMINERS OF SOUTH CAROLINA

AGREEMENT

WHEREAS, the below signed (Applicant) has applied for a Limited License to practice as a Physician Assistant in South Carolina; and

WHEREAS, Applicant has provided documentation that he/she has never previously failed two consecutive National Commission on Certification of Physician Assistants' examination, and he/she has registered for or intends to register to take the next offering of this examination, and that he/she has graduated from a Physician Assistant training program approved by the American Medical Association; and

WHEREAS, Section 40-47-950 of the 1976 S.C. Code, as amended, setting forth the criteria for a Limited License; and

WHEREAS, this Statute explicitly states that if Applicant fails two consecutive NCCPA examinations or fails to register for the next scheduled NCCPA examination, the Limited License shall be "immediately void," and Applicant shall not be eligible for another Limited License; and

WHEREAS, this Statute further makes clear that the Applicant's supervising physician must be "physically present on the premises at all times" when the Applicant "is performing any task."

IT IS THEREFORE UNDERSTOOD AND AGREED THAT:

(1) Applicant acknowledges and agrees that this Limited License is not renewable and is valid only until the results of a limited licensee’s two consecutive NCCPA certifying examinations are reported to the Board. If a limited licensee has failed two consecutive NCCPA certifying examinations and fails to register for the next offering of the NCCPA examination, the limited license is immediately void and the applicant is no longer eligible to apply for further limited licensure.

(2) Applicant further acknowledges that his/her supervising physician must be "physically present on the premises” at all times when he/she is performing any task.

(4) Applicant further acknowledges and agrees that he/she has fully read this Agreement, is familiar with and fully understands the Physician Assistant Practice Act, and further fully understands and consents to the specific provisions and limitations of any Limited License that may be issued pursuant to Section 40-47-950.

(5) Applicant further agrees that he/she will immediately notify this Board, in writing, of any change of address or change regarding the status of his/her supervising physician or employment relationship.

AND IT IS SO AGREED.

STATE BOARD OF MEDICAL EXAMINERS
OF SOUTH CAROLINA

______________________________	______________________________
Physician Assistant Signature	**Date**
______________________________	______________________________
Supervising Physician Signature	**Date**
______________________________	______________________________
Interviewing Board Representative Signature	**Date**