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
llr.sc.gov/med

SPECIAL 14 DAY LIMITED LICENSE REQUIREMENTS AND INSTRUCTIONS – ELECTRONIC APP

A special limited license may be issued to a physician licensed in another state for up to fourteen days not more than four times a year in order to authorize practice under supervision for training involving direct patient care or to explore potential employment relationships.

- Submit payment in the amount of **$75** (application fee) via credit card or electronic check. Fees are non-refundable. A returned check fee of $30, or an amount specified by law, may be assessed on all returned funds.

Information you will need to upload to your online application:

- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your social security card
- Notarized Verification of Lawful Presence
- Notarized Signature Affidavit with 2x2 photo attached
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change

Have sent directly to the Board on your behalf:

- License Verification from each state medical board that you are currently or have ever been licensed in.
- Supervisor Statement from a licensed SC physician relating the purpose of training and dates requested.
- American Medical/Osteopathic Association Physician Profile (AMA or AMO). An AMA or AOA physician profile must be received by the board. Please visit the AMA online at https://commerce.ama-assn.org/amaprofiles/ or the AOA online at www.aoaprofiles.org to request a profile be sent to the LLR-Board of Medical Examiners. You do not need to be a member to have the physician profile sent to the board.

Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Application will be processed within 15 business days of the received date and you will be notified of any deficiencies in your file.

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

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

You may check the status of your application online by visiting the Board's website at www.llr.sc.gov/med and select **Application Status.**

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NOTARIZED SIGNATURE AFFIDAVIT

Certification:

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 medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of 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 medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of 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_____.

Tape a recent 2 x 2
Passport Photo
(less than 6 months old)

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____

(Notary Seal)

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY

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

Section A: LAWFUL PRESENCE in the United States.

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

Check only one box:

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

Date of Birth: _____

Alien Number:_____ I-94 Number: _____

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

Section B: ATTESTATION.

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

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

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

_____
Signature of Affiant

SWORN to before me this_____day of_____, 20_____

_____
Notary Signature

_____
Print Name

Notary Public for _____

My Commission Expires: _____

Rev: 02-02-2015

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

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

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

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

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

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MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

Physician Name _____ Office Telephone No. _____

Address _____ City _____ State _____ Zip _____

MALPRACTICE COMPLAINT:
Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.

Patient's Name: _____

Age: _____ Sex: _____ Date of Occurrence: _____

Place of Occurrence: _____

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

FILED AGAINST: ◯ Individual Doctor ◯ Group ◯ Hospital

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

_____

_____

_____

DISPOSITION: ◯ Pending ◯ Jury Verdict ◯ Settled ◯ Dismissed ◯ Dropped

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Total amount paid (if any): _____ Date paid: _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Date: _____ Signature: _____