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

SUMMARY OF REQUIREMENTS FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

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.

Include with your application:

- Check or money order in the amount of **$120** made payable to LLR – Board of Medical Examiners. (All fees are non-refundable. A returned check fee of up to $30, or an amount specified by law, may be assessed on all returned funds.)
- Notarized Signature Affidavit with a 2"x2" professional photo (Passport Photo)
- Legal documentation for name change, if applicable
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your social security card
- Copy of your current NCCPA Certificate: Visit www.nccpa.net to obtain "verify certificate" page.
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable

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): Board will forward instructions once application is received.

LICENSURE REQUIREMENTS

Section 40-47-945 (A) Except as otherwise provided in this article, 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) submitted a completed application on forms provided by the Board;
(2) paid the non-refundable application fee;
(3) successful completion of an educational program for physician assistants approved by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor organization;
(4) successful completion of the NCCPA certifying examination and provide documentation that he or she possesses a current, active, NCCPA Certificate;
(5) certified that the applicant is mentally and 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;

EDUCATION
Applicant will need to have the Certification of Physician Assistant Education sent in or an official transcript with the conferred date reflected on it.

NCCPA CERTIFICATE
Applicant must provide a copy of their current/active NCCPA Certificate. Visit www.nccpa.net to obtain "verify certificate" page. Proof of current NCCPA Certificate must contain the expiration date.

VERIFICATION OF OUT OF STATE LICENSURE
A license verification from every state an applicant is currently or has previously been licensed is required to be sent in directly from the licensing state board. A License Verification Form is provided as a courtesy; however the SC Medical Board will accept an official state license verification form from the issuing state board.

CRIMINAL BACKGROUND CHECK (CBC)
An applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in Section 40-47-36 of the Medical Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received.

Allow 15 business days for processing before contacting the board regarding the status of your application.
You may check the status of your application by visiting the website at www.llr.sc.gov/pol/medical

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APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT

Include with your application:

- Check or money order in the amount of **$120** 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.
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Copy of your current NCCPA Certificate: Visit: www.nccpa.net to obtain "verify certificate" page.
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change, if applicable

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): Board will forward instructions once application is received.

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

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: _____ Business Phone: _____

Fax: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____

Race: _____ Gender: ☐ Female ☐ Male
(For statistical purposes only) (For statistical purposes only)

Name: _____

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

NCCPA Certificate Number: _____ Expiration Date: _____

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.

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? _____ ☐ Yes ☐ No
   (Complete a Malpractice Information Claim Form for each claim)

8. Do you have any physical or mental disease or condition, including an addiction to drugs or alcohol, that currently interferes with your ability to competently and safely perform the essential functions of practice? (If you are voluntarily enrolled in the Recovery Professionals Program (RPP) and have remained in full compliance, you may answer 'No' with respect to any condition involving abuse of alcohol or drugs. If you have a physical or mental disease or condition that is appropriately being treated and does not currently impair your judgment or otherwise adversely affect your ability to practice, you may answer 'No.') ☐ Yes ☐ No

9. Have you ever discontinued practice as a physician assistant for any reason for three consecutive months or more? ☐ Yes ☐ No

10. Was your medical education/residency training interrupted other than for vacation periods or military service? ☐ Yes ☐ No

11. 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

12. 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

Name: _____

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 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 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_____.

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)

PRIVACY DISCLOSURE

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

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

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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CERTIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Proof of successful completion of an educational program for physician assistants that has been approved by the Commission on Accredited Allied Health Programs or its successor organization is required for licensure. Please have this form completed by the school or have an official transcript sent. Transcript must reflect the conferred date of the degree.

Applicant's Information:

Last: _____ Suffix: _____ First: _____ Middle: _____

Student ID: _____ Contact Number: _____

I am applying for a PA license in the State of South Carolina. Please complete this form and send the original document bearing the institution's official seal to the above listed address.

_____
Applicant's Signature

_____
Date

Please complete this form and include the school seal along with the Dean's, Registrar's, President's or PA Program Director's signature.

It is hereby certified that (student name) _____

of (hometown, state or country) _____ attended (full name of school):

_____ from (dates of attendance): _____ to _____

and received a diploma conferring the degree of: _____

and said diploma bears the following date: _____ .

(Seal)

_____
Signature of Dean, Registrar or PA Program Director

_____
Title

_____
Date

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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: (Not required) _____

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.

Signature: _____ Date: _____

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VERIFICATION OF LICENSURE FORM

Use this form only if it is required by another state.

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

Applicant's Signature: _____

Print Name: _____

Address: _____

FOR STATE BOARD TO COMPLETE

This section to be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners. You may send a state issued license verification in lieu of this form.

Full name of licensee: _____

Graduate of: _____ Date of Degree: _____

State of: _____ License No.: _____ Date Issued: _____

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

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

_____

Comments, if any: _____

_____

Date: _____ Signature: _____

Print Name: _____

Board Seal

Title: _____

Board: _____