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/

SUMMARY OF REQUIREMENTS FOR ACUPUNCTURE PRACTICE

All credential types require the following:

- Submit completed application with non-refundable application fee of $111 and all required documentation listed.

- **Verification of Licensure**: A verification of licensure form or state issued verification form must be received from all state boards in which you are currently or have previously been licensed in.

- **Interview and Temporary License**: When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license.

In addition to the above requirements:

Licensed Acupuncturist applicants need to:

- Request verification of your active certification in acupuncture from the National Commission for the Certification of Acupuncturists and Oriental Medicine (NCCAOM). The verification must be submitted by the NCCAOM.

Auricular Therapy applicants need to:

- Submit a copy of your certification as having been trained to utilize auricular points with your application;
- Submit proof of successful completion of a national certified program approved by the Acupuncture Advisory Committee and the State Board of Medical Examiners with your application;
- Submit the original signed Supervisor Form with your application. Auricular therapy may take place under the direct supervision of a licensed acupuncturist or a person licensed to practice medicine.
- Request the provider of the course to submit proof of successful completion of a nationally recognized clean needle technique course.

Note: Treatment by an auricular therapist is strictly limited to inserting needles into the ear. Inserting needles anywhere else on the body is considered practicing acupuncture without a license.

Auricular Detoxification Therapy need to:

- Submit proof of successful completion of a nationally recognized training program in auricular detoxification therapy for the treatment of chemical dependency detoxification and substance abuse.
- Submit the original signed Supervisor Form with your application. Auricular detoxification therapy may take place under the direct supervision of a licensed acupuncturist or a person licensed to practice medicine.

Note: Treatment by an auricular detoxification therapist is strictly limited to the five ear-point treatment protocol for detoxification, substance abuse, or chemical dependency as stipulated by the National Acupuncture Detoxification Association (NADA).

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Application to Practice Acupuncture

Include with your application:

- Check or money order in the amount of $111 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 Drivers License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Legal documentation for name change, if applicable

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

- License Verification from each state medical board that you are currently or have ever been licensed in.

Select what you are applying for and reference the required documentation listed below your selection:

- **For Licensed Acupuncturist Only:**
  - Have submitted by the issuing agent: Copy of your active certification in acupuncture by the National Commission for the Certification of Acupuncturists and Oriental Medicine (NCCAOM)
- **For Auricular Therapy Only:**
  - Have submitted by issuing agent: Copy of your certificate documenting successful completion of a nationally recognized clean needle technique course.
  - Completed Supervisor Form
- **For Auricular Detoxification Therapy Only:**
  - Copy of your certificate in auricular detoxification therapy for the treatment of chemical dependency and substance abuse.
  - Have submitted by the issuing agent: Copy of your certificate documenting successful completion of a nationally recognized clean needle technique course.
  - Completed Supervisor Form

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

Applying for: ☐ **Licensed Acupuncturist** ☐ **Auricular Therapist** ☐ **Auricular Detoxification Therapist**

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: _____

Business Address: _____ Phone: _____

Fax: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____ Place of Birth: _____

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

Name: _____

II. PROFESSIONAL EDUCATION INFORMATION

List in chronological order from date of graduation all professional education. 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. 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: _____

V. PERSONAL HISTORY INFORMATION

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

1. Have you ever had any application for any professional license, certification or registration denied or refused by any licensing authority? YES ☐ NO ☐

2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? YES ☐ NO ☐

3. Have you ever been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility or staff of such facility? YES ☐ NO ☐

4. Have your privileges ever been restricted or terminated by any association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures? YES ☐ NO ☐

5. To your knowledge, are there any unresolved or pending complaints against you with any federal or state agency, professional association, licensed hospital/clinic, or staff of such hospital/clinic? YES ☐ NO ☐

6. Do you currently have any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice? YES ☐ NO ☐

7. 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 ☐

8. 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 ☐

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.

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 an acupuncturist 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 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: _____

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

(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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SUPERVISING PHYSICIAN OR ACUPUNCTURIST FORM

I will be supervising:

Therapist Name: _____

Type: Auricular Therapist Auricular Detoxification Therapist

Supervising Physician or Acupuncturist Information:

Name: _____ SC License Number:

Address - Street:_____ City:_____State:_____Zip:_____

Telephone:_____ Email: _____

1. List and attach copies of all acupuncture training.

School	Course	Date completed
_____	_____	_____
_____	_____	_____

2. Describe below the nature of the working relationship for the auricular therapist or auricular detoxification therapist. (Attach additional pages if necessary)

_____

_____

_____

3. Describe below the types of conditions for which acupuncture will take place. (Attach additional pages if necessary)

_____

_____

_____

- I acknowledge and agree, if approved by the Board, that I shall be responsible for supervising the auricular therapist or directly supervising the auricular detoxification therapist named in this application. I further acknowledge that as the supervising physician or acupuncturist, I will be available to attend to any unexpected, adverse effects.

- I agree that should I become aware of any unethical, unprofessional or illegal acts or omissions on the part of the auricular therapist or auricular detoxification therapist, I shall immediately report such conduct in writing to the State Board of Medical Examiners of South Carolina.

- I have carefully read the above questions and answered them completely and I declare that all statements made by me herein and materials supplied herewith are true and correct. Further, if approved as the supervising physician or acupuncturist of this auricular therapist or auricular detoxification therapist, **I agree to keep the Board informed of any future changes in my address or working relationship with this auricular therapist or auricular detoxification therapist**.

_____ _____

Supervising Physician or Acupuncturist Signature Date