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/

Reactivation Application-Respiratory Care Practitioner

Include with your application:

- Check or money order in the amount of $160.00 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 Type Photo)
- 30 hours of CME obtained within two years of application date
- License verification from all other states of licensure
- Signed statement from Physician Sponsor, if applicable
- Legal name change document, if applicable (marriage certificate, divorce decree, etc.)

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

- 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

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: _____

Date of Birth: _____ Social Security No.: _____

Place of Birth (City, State or Country): _____

Race: _____ Gender: ☐ Female ☐ Male

Employment Name If Known: _____ Phone: _____

Fax: _____ Email Address: _____

SC Medical Director: _____
(If not known at this time, mark "unknown at this time")

NOTE:
Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, license verifications, etc.

Name: _____

II. PRACTICE AND EMPLOYMENT STATEMENT

List below all practice and employment since your license became inactive. This statement must include all employment, job titles and job duties.

Please note: If you will care for cardio-pulmonary patients in a home care setting, you must attach a statement signed by your physician sponsor with details about your duties and level of supervision.

FROM Month / Yr	TO Month / Yr	EMPLOYER NAME	OFFICE ADDRESS	TYPE OF PRACTICE

III. OTHER STATES OF LICENSURE

List all states in which you have ever been licensed or certified to practice as a Respiratory Care Practitioner. A license verification from each state should be sent directly to the SC Board.

State	License/Certificate Number	Date Issued	Basis of Licensure/Certification	Status [Active/Inactive/Lapsed

IV. REPORT OF CONTINUING EDUCATION

In order to reactivate your Respiratory Care License, you must provide documentation of at least thirty (30) hours of continuing medical education. Proof of attendance must be provided in the form of certificate, diploma or printout. These hours must be obtained within the last 2 years of this application.

V. PERSONAL HISTORY INFORMATION

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

1. Has your Respiratory Care Practitioner certificate/license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a medical licensing board or other entity?

   YES ◯ NO ◯

2. Have you ever had an application to practice as a Respiratory Care Practitioner 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 resigned from any hospital, institution or health care facility in lieu of disciplinary action?

YES ◯ NO ◯

5. 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 ◯

6. 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 Respiratory Care Practitioner?

YES ◯ NO ◯

7. 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 Respiratory Care Practitioner?

YES ◯ NO ◯

8. Is your ability to practice as a Respiratory Care Practitioner currently impaired by any physical or mental illness or by the use of alcohol or drugs?

YES ◯ NO ◯

9. Within the past two (2) years, has your ability to practice as a Respiratory Care Practitioner been impaired by any physical or mental illness or by the use of alcohol and/or drugs?

YES ◯ NO ◯

10. Have you ever discontinued the practice as a Respiratory Care Practitioner for any reason for three consecutive months or more?

YES ◯ NO ◯

11. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license?

YES ◯ NO ◯

12. Have you ever been discharged involuntarily from employment? If so, give full details.

YES ◯ NO ◯

13. 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 a Respiratory Care Practitioner 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 Respiratory Care Practitioner 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

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

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____ (Notary Seal)

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)

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: _____

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