South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, P.O. Box 11289
Columbia, South Carolina 29211
(803) 896-4500

VOLUNTEER LIMITED LICENSE RENEWAL APPLICATION

NOTE: Application must be fully completed with all requested information and documentation supplied.

(Please type or print clearly)
I hereby make application to renew my current Volunteer Limited License in the state of South Carolina and submit the following statement of facts with the required supporting documents. *The application form itself is a public document obtainable under the Freedom of Information Act*.

Applicant's Name _____
Last First Middle

Home address:

_____
Street address

_____
City State Zip

_____
Home telephone number

_____
*Social Security Number

Date of Birth _____
Month Day Year

South Carolina practice address:

_____
Hospital Name

_____
Street Address

_____
City State Zip

_____
Office telephone number

Type of training/practice_____

SC Volunteer Limited License Number_____

Supervising physician name _____

Supervising physician name _____

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

South Carolina Law requires the agency collect personal information which is only disseminated as required by law. 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 your renewal application and other documents on file, 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. In order to better protect the information you provide, please provide the Department with the following information that may be released to the public upon request: a public mailing address, a public email address and a public telephone number.

CONTROL# _____
CHECK# _____
AMOUNT $_____

PERSONAL DATA

**** If you are currently enrolled in the Recovering Professional Program (RPP), you may answer "No" to this question**.

Since you last applied with this office for your Volunteer Limited License: **Answer Yes or No**

1. Has your medical license been revoked, suspended, reprimanded, restricted or placed on probation by any medical licensing board or other entity? Yes ☐ NO ☐
2. Have you had an application to practice medicine denied or refused by another medical licensing board or entity? Yes ☐ NO ☐
3. Have you had hospital privileges denied, revoked, suspended or restricted in any way? Yes ☐ NO ☐
4. Have you voluntarily surrendered a medical license, controlled substance registration or DEA registration? Yes ☐ NO ☐
5. Have you 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. Is your medical license currently restricted in any way by any medical licensing board, or other entity? Yes ☐ NO ☐
8. Have you had a malpractice lawsuit, judgment or settlement filed against you? If so, how many? _____ Yes ☐ NO ☐
9. 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?** Yes ☐ NO ☐
10. 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 the practice of medicine?** Yes ☐ NO ☐
11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs? Yes ☐ NO ☐
12. Have you discontinued the practice of medicine for any reason for three consecutive months or more? Yes ☐ NO ☐
13. Has your ability to prescribe controlled substances been denied, revoked, suspended or limited by any hospital, health care facility or other entity? Yes ☐ NO ☐
14. Have you been convicted, pled guilty or pled *nolo contendere* for violation of any federal, state or local law (other than a minor traffic violation)? Yes ☐ NO ☐
15. Have you ever been known by any other name or surname? Yes ☐ NO ☐

NOTE: If you answered "Yes" to any of the above questions (1-15), you must attach a full written explanation pertaining to that particular question.

I have carefully read all questions in this application and have answered them fully, accurately, and completely. I hereby agree that my failure to answer all questions or make full disclosure of any facts or information called for in this application shall constitute cause for the denial of my application or for the revocation of my license to practice medicine in South Carolina. I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary 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, and to federal and state entities, as required by law.

Applicant's Signature_____ Date_____