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

APPLICATION FOR A VOLUNTEER LIMITED LICENSE

Include with your application:

- Copy of your valid Driver's License, State-Issued ID or Passport
- Copy of your Social Security card
- A 2"x2" professional photo (Passport Photo)
- Notarized verification of lawful presence
- Malpractice Claim Information Form, if applicable
- Copy of ABMS and/or AOA Certificate(s), if applicable
- Supervisor Form
- ECFMG Certificate, if applicable
- Legal documentation for name change (marriage cert., divorce decree, court order, etc.), if applicable

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

- License verification from each state medical board by which you are currently or have ever been licensed
- Official school transcripts

Note for SC residents: To find your congressional district you may go to: http://www.scstatehouse.gov/legislatorssearch.php

APPLICANT INFORMATION

Title: ☐ M.D. ☐ D.O.

Last Name: _____ First: _____ Middle: _____ Suffix: ____

Since your initial licensure, have you legally changed your name? ☐ Yes ☐ No Prior 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 No.: _____ Email: _____

Date of Birth: _____ Social Security No.: _____

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

Supervising Physician Name: _____ Phone: _____

License No.: _____ Email: _____

SC Location Information

Name of Hospital/Clinic: _____

Complete Address: _____

PROFESSIONAL EDUCATION INFORMATION

List in chronological order from date of 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

Are you a graduate from a medical school located outside of the United States or Canada? ☐ Yes ☐ No

If yes, ECFMG Certificate No.: _____

Is this a permanent certificate? ☐ Yes ☐ No

INTERSHIP AND RESIDENCY TRAINING INFORMATION

Complete the requested information below on all training programs completed in the US or Canada. Failure to disclose any training program information may result in the denial of your application or other appropriate action. Attach an additional sheet, if necessary.

School Name	Location (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Did you complete the program?

RECORD OF EXAMINATION

Complete the requested information below if licensure examination was taken in this state or any other state. List each examination (National Boards, FLEX, USMLE, etc.) attempts below. Attach additional sheet, if necessary. Do not include ABMS/AOA Board Certification.

Name of Examination	Location (State or Country)	Date of Exam	Passed/Failed Score

RECORD OF LICENSURE

List all states in which you have been licensed 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 SC Board of Medical Examiners at the above listed address. We provide a Verification of Licensure 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 SPECIALTY

1. What is your current medical specialty? _____
2. **Are you Board certified/recertified by the (**If yes, attach a copy of the certificate):

   If yes, date you were certified/recertified: _____

   ☐ American Board of Medical Specialties (ABMS)

   ☐ American Osteopathic Association (AOA)

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 (MM/YY)	To (MM/YY)	Employer Name	Office Address	Type of Practice

PERSONAL HISTORY QUESTIONS

If you answer "Yes" to any of the questions below, submit a detailed letter of explanation along with any other relevant documentation.

1. Has your medical 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 medicine 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? _____
(Complete a Malpractice Claim Information form for each claim) ☐ Yes ☐ No

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 the practice of medicine 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

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 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 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)

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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SUPERVISING PHYSICIAN FORM
FOR VOLUNTEER LIMITED LICENSEES

VOLUNTEER LIMITED LICENSEE

Last Name:_____ Suffix:____ First:_____ Middle:_____

SUPERVISING PHYSICIAN INFORMATION

SC License Number: _____

Last Name:_____ Suffix:____ First:_____ Middle:_____

Phone: _____ Email: _____

Business Name: _____ Type of Practice: _____

Business Address:_____ City:_____ State:___ Zip:_____

Are you board certified by an ABMS or AOA Specialty Board? ☐ Yes ☐ No

If yes, Specialty: _____ Date of Certification/Recertification: _____

- I acknowledge and agree, if approved by the Board, that I shall be responsible for the Special Volunteer Licensee named above.
- I further acknowledge that this Special Volunteer Licensee shall be permitted to practice medicine only when I, or another physician approved by the SC medical Board, am physically present with this licensee.
- I agree that should I become aware of any unethical, unprofessional or illegal acts or omissions on the part of the Special Volunteer Licensee, or any acts or omissions that violate the terms and conditions of the Special Volunteer License, I shall immediately report such conduct in writing to the SC Board of Medical Examiners.
- I understand the Special Volunteer Licensee is not to receive any compensation or payment, direct or indirect for the rendering of medical services, and that I shall receive no payment or compensation resulting from the Special Volunteer Licensee's provision of medical services.

_____	_____	_____
Supervising Physician Signature	S.C. License No.	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: _____