South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
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P.O. Box 12367 • Columbia • SC 29211-2367
Phone: 803-896-4550 • NURSEBOARD@llr.sc.gov • Fax: 803-896-4515
llr.sc.gov/nurse

REQUIREMENTS AND INSTRUCTIONS FOR REINSTATEMENT / REACTIVATION SOUTH CAROLINA ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSE

Information for Applicant

South Carolina is a member of the Nurse Licensure Compact (NLC). The NLC does not affect additional requirements imposed by states for advanced-practice registered nursing. A multi-state licensure privilege to practice registered nursing granted by a party state must be recognized by other party states as a license to practice registered nursing if a license to practice registered nursing is required by state law as a precondition for qualifying for advanced-practice registered nurse authorization.

A current South Carolina APRN license or temporary license is required to practice advanced nursing in this state. Orientation is considered the practice of nursing in South Carolina. Therefore, all nurses must possess a current South Carolina license and/or temporary license before beginning orientation (including classroom instruction and reading policies and procedures). It is a violation of the Nurse Practice Act to begin orientation without the proper license and can result in action by the Board. Please visit our website at https://llr.sc.gov/nurse/ to review the complete South Carolina Nurse Practice Act, Chapter 33, Section 40-33-34 for more details on educational and certification requirements.

South Carolina Nurse Practice Act §40-33-20. Definitions.

(31) "Inactive license" means the official temporary retirement of a person's authorization to practice nursing upon the person's notice to the board that the person does not plan to practice nursing or the status of a license that does not currently authorize a licensee to practice nursing in this State.

(34) "Lapsed license" means the termination of a person's authorization to practice nursing due to the person's failure to renew his or her nursing license within the renewal period.

The Board may reinstate/reactivate an APRN licensee from inactive/lapsed status upon payment of reactivation/reinstatement fee and furnish evidence satisfactory that applicant has met requirements for licensure as provided in§40-33-34.

An applicant for licensure as an Advanced Practice Registered Nurse (APRN) shall furnish evidence satisfactory to the board that the applicant:

(1) has met all qualifications for licensure as a registered nurse; and
(2) holds current specialty certification by a board-approved credentialing organization. New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion; and
(3) has declared specialty area of nursing practice and the specialty title to be used must be the title which is granted by the board-approved credentialing organization or the title of the specialty area of nursing practice in which the nurse has received advanced educational preparation.

According to the Nurse Practice Act, Chapter 33, Section 40-33-40:

(B) Demonstration of competency for:

(2) reinstatement from lapsed or inactive status of *five years or less* requires documented evidence of at least **one** of the following within the preceding two years:

a) completion of thirty contact hours from a continuing education provider recognized by the board and successful completion of a course in legal aspects approved by the board;
b) maintenance of certification or recertification by a national certifying body recognized by the board;
c) completion of an academic program of study in nursing or a related field recognized by the board;

d) verification of competency and the number of hours practiced, as evidenced by **employer certification** on a form approved by the board; or
e) successful completion of a refresher course approved by the board;

(3) reinstatement from lapsed or inactive status of *more than five years* requires documented evidence of at least one of the following within the preceding two years:

a) successful completion of a refresher course approved by the board; or
b) successful completion of the NCLEX appropriate to the area of licensure.

(C) Demonstration of competency for reinstatement from lapsed or inactive status or licensure of a person who holds a current authorization to practice in another state or jurisdiction in this country or territory or dependency of the United States requires documented evidence of at least one of the requirements in subsection (B) during the preceding two years.

PRESCRIPTIVE AUTHORITY

APRN's applying for prescriptive authority shall meet the requirements as noted in the S.C. Nurse Practice Act, Section 40-33-34 (E). We recommend having your supervising physician and written protocol in place before applying. The written protocol does not need to be submitted unless you are audited by the SCBON. The SCBON will notify you in advance if you are being audited.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS

§40-33-25 of the SC Nursing Practice Act requires all nursing applicants to submit a fingerprint based criminal background check. Instructions for the fingerprint process will be sent to you **after** your application for licensure is received by the SCBON. DO NOT have your fingerprints or CBC report processed until you have submitted an application and received instructions from the SCBON.

VERIFICATION OF LEGAL NAME

A license must be issued in the nurse's legal name as verified by a birth certificate or other legal document acceptable to the board. Examples of acceptable documents include a valid passport, vital statistics birth certificate (not hospital birth certificate), marriage certificate, divorce decree or court order approving legal name change.

SAFEGUARDING PATIENT RECORDS

Regulation 91-33 requires that each Advanced Practice Registered Nurse (APRN) licensee actively practicing within the State of South Carolina, in a solo practice setting, shall designate a partner, personal representative, or other responsible party to assume responsibility for patient medical records in the case of incapacity, death or disappearance of the licensee, including any circumstances whereby the licensee is unable for any reason to provide continuity of care, appropriate referral or patient medical records upon a valid request of the patient. Each APRN nurse licensee must identify by name, address, and telephone number of their designee on each application for initial licensure, renewal, and reinstatement.

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REINSTATEMENT/REACTIVATION APPLICATION FOR APRN LICENSE

Include with your application:

- Check or money order made payable to LLR-SC Board of Nursing (SCBON). 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 Social Security card
- 2" x 2" Color Passport type photo (Must be less than 6 months old.)
- Proof of legal name if it has changed: (vital statistics birth certificate (not hospital birth certificate), valid Passport, marriage certificate, divorce decree, or court order approving a legal name change)
- Proof of competency **(national certification)**
- Proof of Specialty Certification **(if applicable)**

Criminal Background Check instructions will be provided via email by Board staff after the application is received.

Fee Amounts - check the type/method of application: Application fees are non-refundable.

REINSTATEMENT:

☐ APRN Reinstatement of lapsed license $195.00 (Reinstatement Fee + Renewal Fee)

☐ APRN Reinstatement of lapsed license with Prescriptive Authority $235.00 (Reinstatement Fee + Renewal Fee)

REACTIVATION:

☐ APRN Reinstatement of inactive license $70

☐ APRN Reinstatement of inactive license with Prescriptive Authority $90

APPLICANT INFORMATION

License Type: _____ Prior License No.: _____

Last Name:_____First:_____Middle:_____Suffix:_____

Since you were last actively licensed, 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)

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

Mailing Address: _____City:_____State:____Zip:_____
(If different than above)

Phone: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____

SAFEGUARDING PATIENT RECORDS

1. Are you actively practicing in a solo practice setting? ☐ Yes ☐ No
   If Yes, pursuant to Reg. 91-33 (Safeguarding Patient Records), please provide the name, address and phone number of the individual that you have designated to assume responsibility of your patient records: _____

Applicant Name: _____

PRIMARY STATE OF RESIDENCY

If you are applying for **an RN** multi-state license **(within the APRN license)** and do not have proof of residency, you will be issued a single state license until the *Declaration of Primary State of Residence Form* and a copy of your proof of residency are received.

1. What type of license are you applying for: ☐ Single State ☐ Multi-State
2. What is your current primary state of residence? _____

   If it is not SC, do you anticipate taking permanent residence in SC? ☐ Yes ☐ No

   If yes, when? _____
3. Are you in the military or do you work for the Federal government? ☐ Yes ☐ No
   a) If yes, what state are you currently licensed? _____
   b) Do you intend to work outside of the military or Federal government? ☐ Yes ☐ No

OUT OF STATE LICENSURE

1. Do you currently hold an out-of-state license? ☐ Yes ☐ No

PERSONAL HISTORY INFORMATION

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

SINCE YOU WERE LAST ACTIVELY LICENSED IN SC:

1. Have you had an application for any professional license, certification, or registration refused or denied by any licensing authority? ☐ Yes ☐ No
2. Have you been refused or denied the privilege of taking an examination required for any professional license? ☐ Yes ☐ No
3. Have you 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 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 have any unresolved or pending complaints been filed against you with any federal or state agency, professional association, licensed hospital or clinic, or staff of such hospital or clinic? ☐ Yes ☐ No
6. Have you been arrested, charged or convicted (including a nolo contendere plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? Note: A DUI is not a minor traffic violation. If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities. ☐ Yes ☐ No
7. 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.") If Yes, attach a brief letter of explanation. Include your name, license number and daytime telephone number where you can be reached. ☐ Yes ☐ No
8. Have you ever voluntarily surrendered a nursing license? ☐ Yes ☐ No

ATTESTATION

I, _____ , am the person described and identified and the person named in all documents presented in support of this application. I certify that I have never been convicted of violating any Federal, State, Municipal or other law, statute or ordinance, other than as disclosed as required within this application.

I have carefully read the questions within this 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 to the best of my knowledge and belief.

Should I furnish any false, incomplete, or misleading information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license in South Carolina.

I certify I am the person shown in the photograph below and it has been taken within the last 6 months.

_____
Applicant Signature

_____
Print Applicant Name

Tape Passport Type
Color Photo Here
2 x 2

SWORN to before me this ____ day of _____ , 20____

Notary Signature: _____

Print Name: _____

Notary Public for the State/Providence of: _____ SEAL

My Commission Expires: _____

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)

APPLICATION FOR PRESCRIPTIVE AUTHORITY

DO NOT FAX OR EMAIL APPLICATIONS – THEY WILL NOT BE PROCESSED.

- Complete this prescriptive authority application and submit with the required $20 fee. You may submit a check or money order in the amount of $20, payable to the SC Board of Nursing. Application fees are non-refundable and non-transferable. A returned check fee of up to $30, or an amount specified by law may be assessed on all returned or insufficient funds.

- Submit supporting documentation as indicated in the Requirements above, if applicable.

Application By:

☐ **Initial Application** ☐ **Endorsement Application**

☐ **Reactivate/Reinstate - Date license inactive/expired:** _____

APPLICANT INFORMATION

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

Mailing Address: _____
(Street, City, State, Zip)

Phone: _____ Last 5 of SSN: _____ SC License No.: _____
(NP, CNM or CNS)

Email Address: _____

Primary Practice/Agency: _____ Phone: _____

Address: _____
(Street, City, State, Zip)

PRESCRIPTIVE AUTHORITY INFORMATION

1. Do you have an active NP, CNM or CNS license with Prescriptive Authority in another state? ☐ Yes ☐ No
   If **YES**, you will need to provide a copy of your out-of-state DEA registration or a copy of a license verification that shows where you held prescriptive authority.

2. Will you be participating in Telemedicine? ☐ Yes ☐ No

PERSONAL HISTORY QUESTIONS

Please respond to all questions. If you answer "Yes" to any question, you must attach a written explanation. In addition, if you answer "Yes" to any question, you may be requested to appear before the full Board to answer additional questions and/or provide additional information.

1. **Since you were initially licensed or since your last renewal:** Have you 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

2. **Since you were initially licensed or since your last renewal:** Have your privileges 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

3. **Since you were initially licensed or since your last renewal:** To your knowledge have any unresolved or pending complaints been filed against you with any federal or state agency, professional association, licensed hospital or clinic, or staff of such hospital or clinic? ☐ Yes ☐ No

4. **Since you were initially licensed or since your last renewal:** Have you been arrested, charged or convicted (including a nolo contendere plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? ☐ Yes ☐ No

   If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities.

5. **Since you were initially licensed or since your last renewal:** Have you been diagnosed and/or been treated for a substance abuse disorder or any physical, mental or emotional condition which in any way currently affects or limits your ability to practice nursing safely and in a competent and professional manner? ☐ Yes ☐ No

6. Are you participating in a substance abuse and/or alcohol, drug treatment, or monitoring program? ☐ Yes ☐ No

We recommend having your collaborating physician and written practice agreement in place before applying. The written practice agreement does not need to be submitted unless you are audited by the SCBON. The SCBON will notify you in advance if you are being audited.

I HEREBY swear/affirm the statements made in this application to be TRUE to the best of my knowledge.
A copy of the signed and dated practice protocols are on file in the office/agency of my employment and will be made available upon request.

Signature of Applicant _____ Date _____

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.

Advanced Practice Registered Nurse (APRN) (Nurse Practitioner, Certified Nurse Midwife, or Clinical Nurse Specialist)

New Employment / Change of Practice Request Form / Prescriptive Authority

(§40-33-34 (D) (3) and (H)(4) – APRNs must submit a change of practice form within 15 days of change)

Return this completed form by logging into https://eservice.llr.sc.gov/DocumentSubmission or email to nurseboard@llr.sc.gov for processing.

PLEASE DO NOT FAX.

Select type of Advanced Practice that applies to you:

☐ **Nurse Practitioner (NP)** ☐ **Certified Nurse-Midwife (CNM)** ☐ **Clinical Nurse Specialist (CNS)**

Last Name	**First Name**	**Middle Name**	**Maiden Name**

Home Address (Street, City, State, Zip):	**Home Phone:**

Last five of SSN:	**SC License #:**	**Specialty Area:**

Reminder: All physicians can only work with no more than six (6) NPs, CNMs, CNSs, or PAs at any one time without prior approval by the SC Board of Medical Examiners. Updates/changes must be submitted to the Board within 15 days of change. If you have questions, please send an email to NurseBoard@LLR.SC.GOV.

☐ **New Employment** ☐ **Change of Practice Site(s)** ☐ **Change of Physician(s)**

☐ **Additional Practice Site(s)** ☐ **Additional Physician(s)** ☐ **Reinstatement of RX**

(If RX has been removed over 6 months, applicant must reapply for RX by submitting an application.)

☐ **Remove Physician(s)** **1.**_____ Lic. #_____ **2.**_____ Lic. # _____

3._____ Lic. #_____ **4.**_____ Lic. # _____

PRIMARY Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):**	
	Practice Address: (Street, City, State, Zip Code)	
☐ **Primary Physician** ☐ **Alternate Physician**	**Collaborating Physician** (All physicians must have a permanent SC license in good standing)	
	Business Address: (Street, City, State, Zip)	
SC Physician's License No:	**Practice Specialty:**	**Primary Practice Site Phone Number**

COLLABORATING PHYSICIANS MUST BE PHYSICALLY PRESENT AT A PRACTICE SITE LOCATED WITHIN THE GEOGRAPHIC BOUNDARIES OF SC. CODE SECTION 41-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-196.

Signature of Collaborating Physician **Date**

SECONDARY/ADDITIONAL Practice Site **(If more than 2 sites, duplicate form as needed)**	**Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):**	
	Practice Address: (Street, City, State, Zip)	
☐ **Primary Physician** ☐ **Alternate Physician**	**Collaborating Physician** (All physicians must have a permanent SC license in good standing)	
	Business Address: (Street, City, State, Zip)	
SC Physician's License No:	**Practice Specialty:**	**Secondary Practice Site Phone Number**

COLLABORATING PHYSICIANS MUST BE PHYSICALLY PRESENT AT A PRACTICE SITE LOCATED WITHIN THE GEOGRAPHIC BOUNDARIES OF SC. CODE SECTION 41-47-195.

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-196.

Signature of Collaborating Physician **Date**

A copy of the written practice agreement, for NP, CNM, or CNS signed and dated by all the physicians listed above and myself are on file in the office/agency of my employment and available upon request. ☐ **YES** ☐ **NO**

Please do not send written practice agreements unless requested.

I HEREBY Swear/affirm the statements made in this document to be TRUE to the best of my knowledge.

_____ _____

Signature and Title of Applicant **Date**