South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
P.O. Box 12367 • Columbia, SC 29211
Phone: 803-896-4550 • Fax: 803-896-4515 • www.llronline.com/POL/nursing/

INSTRUCTIONS AND REQUIREMENTS
ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSURE BY ENDORSEMENT

Nurse Practitioner, Certified Nurse-Midwife, Certified Registered Nurse Anesthetist and Clinical Nurse Specialist
Licensed in another state or RN License inactive in SC - Seeking APRN License in SC

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 APRN South Carolina 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 www.llr.state.sc.us/pol/nursing to review the complete South Carolina Nurse Practice Act, Chapter 33, Section 40-33-34 for more details on educational and certification requirements.

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 earned a master's degree from an accredited college or university, except for those applicants who:
    (a) provide documentation as requested by the board that the applicant was graduated from an advanced, organized formal education program appropriate to the practice and acceptable to the board before December 31, 1994; or
    (b) graduated before December 31, 2003, from an advanced, organized formal education program for nurse anesthetists accredited by the national accrediting organization of that specialty. CRNA's who graduate after December 31, 2003, must graduate with a master's degree from a formal CRNA education program for nurse anesthetists accredited by the national accreditation organization of the CRNA specialty. An advanced practice registered nurse must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty;
(4) has paid the board all applicable fees; and
(5) 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.

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).

An applicant for licensure as an Advanced Practice Registered Nurse whose license in another state is currently restricted to prohibit the practice of nursing by any disciplinary action (i.e. suspension, revocation, or other action) shall not be considered for South Carolina license until the license from the other state of discipline is reinstated to permit the practice of nursing.

Instructions & Information

1. Complete and submit the Application for Advanced Practice Registered Nurse License by Endorsement. Application fees are non-refundable. Money order, cashier's check or personal check should be made payable to **LLR-Board of Nursing**. Your application must include the following:
    a) Recent 2"x 2" full faced passport type photo, signed, dated and taped onto application.
    b) Copy of birth certificate or a valid passport. (Copy of hospital birth certificate is not accepted).
    c) Copy of social security card, permanent resident card or a resident alien identification card assigned to a resident alien who does not have a social security number.

d) Copy of a current license from another state with the expiration date.
e) Have official transcript(s) sent directly from master's of nursing educational program to Board of Nursing.
f) Submit copy of current national advanced practice specialty certification (see web page for approved organizations). 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.
g) Copies of legal documents that authorize a change in name (marriage license, divorce decree, court order).
h) Complete Affidavit of Eligibility and submit secure and verifiable document.
i) Obtain all SC physician signatures and license numbers to be included on your application, if applicable.
j) Review the SC Nurse Practice Act and SC Medical Practice Act for guidelines on the development of written protocols.
k) Applicants applying for Prescriptive Authority, complete and submit the following: 1) Prescriptive Authority application; 2) Certificates of completion for 45 hours of pharmacotherapeutics of which 15 hours must be in controlled substances (initial applicants); or 20 hours of pharmacotherapeutics of which 15 hours must be in controlled substances (applicants licensed in another state with prescriptive authority).
l) Application fees - Money order, cashier's check or personal check made payable to LLR-Board of Nursing.
   - $130.00 – Permanent license only.
   - $140.00 – Temporary license & permanent license.

2. Submit the verification form to your original state board of RN licensure **and** Advanced Practice Licensure; or if your original state of RN licensure is a member board of NURSYS, process your RN verification online at **https:\\www.nursys.com** and send the verification form to your original state of Advanced Practice Licensure.
   a. Most boards of nursing charge a fee for this service; therefore, you must contact the state nursing board for the amount required. Verifications must be submitted directly to the South Carolina Board of Nursing. Be sure to send the verification form along with applicable fees to the original licensing board as soon as possible as this process may take several weeks to complete. If your RN nursing education is not included on your verification, then you are required to have an official transcript sent directly from your nursing education program to the SC Board of Nursing office.

3. Temporary License-Temporary licenses are not available to applicants with prior criminal conviction(s), pending criminal charge(s), current board of nursing disciplinary sanction(s) or pending board action(s). A personal written letter of explanation outlining the details of all affirmative answers must be provided with your application.

4. Name Used on License - All licenses are issued in the applicant's legal name. The name as it appears on your birth certificate will be printed on your license, unless it has been changed legally by marriage, divorce or other legal action. If your name changes (marriage, divorce or other court order) after the application has been filed, a copy of the legal document changing your name must be submitted to this office so that the correct name appears on the license. Your first name cannot be dropped and your middle name used on the license unless you have legally made this change and have provided documentation (court documents).

5. Notification of Initial Employment or Change of Practice –Section 40-33-34 (D)(3) and (H)(4) of the S.C. Nurse Practice Act requires that individuals who change or discontinue practice settings or physician (or dentist) shall notify the Board of such change within 15 business days and provide verification of approved written protocols (guidelines). Failure to notify the Board of a practice change shall be considered misconduct and subjects the licensee to disciplinary action. Complete the enclosed notification form and return to the Board of Nursing within the designated time as described in the Statue. The notification form can be copied as needed.

6. License Renewal - South Carolina Nursing Licenses are renewed every even year. All licenses must be renewed by April 30th every even year. It is the licensee's responsibility to renew their license. Do not wait until renewal time to notify the Board of a change in your address, supervisory or practice setting. See §40-33-40 of the Nurse Practice Act to review the competency requirements and §40-33-34(E) (3) for prescriptive authority renewal requirements.

Criminal Background Check (CBC):

An applicant for a license to practice nursing in South Carolina shall be subject to a criminal history background check as defined in 40-33-25 of the Nursing Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received.

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APPLICATION FOR ADVANCE PRACTICE REGISTERED NURSE (APRN) LICENSURE BY ENDORSEMENT

Complete all sections of this application by providing all of the requested information. Please print. Answer all questions and submit with proper fee. Careful completion of this application will avoid a delay in processing. You must notify the Board in writing within fifteen (15) business days of any address changes after you file this application in order to receive information from the Board. This application form is a public document obtainable under the Freedom of Information Act. Personal information provided in this application may be subject to public scrutiny or release under the SC Freedom of Information Act or other provisions of federal and state law. 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 board to report to the National Practitioner Data Bank (NPDB), among other things. The 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.

If you were previously licensed by the South Carolina Board of Nursing as an APRN, do not complete this application form. Visit the Board of Nursing Website at www.llr.state.sc.us/pol/nursing for APRN Reactivation/Reinstatement application to reinstate your APRN license.

Applying as: ☐ **Nurse Practitioner** ☐ **Certified Nurse-Midwife** ☐ **Certified Registered Nurse Anesthetist** ☐ **Clinical Nurse Specialist (CNS)**

PART I: Applicant Identifying Information

1. **Last Name**	2. **First Name**	3. **Middle Name**	4. **Suffix (Jr., III)**

5. **Title** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	6. **Maiden Name**	7. **Social Security Number**

8. Mailing Address (Street or PO Box, City, State, Zip)

9. **Home Address** (Street, City, State, Zip – **not PO Box**)	9a. **County**

9b. **Home Phone**	9c. **Home Fax**	9d. **Home Email**

10. **Identify Preferred Mailing address.** ☐ Mailing ☐ Home

11. **Place of Birth** (City, State & Country)	12. ***Date of Birth MM/DD/YYYY***	13. **Gender** ☐ Male ☐ Female	14. **Race (For Statistical Purposes Only)** ☐ African American/Black ☐ American Indian ☐ Asian ☐ Hispanic/Spanish Origin ☐ Caucasian/White ☐ Other

15 Have you ever been licensed in South Carolina? If yes, SC Registered Nurse (RN) License Number_____ **YES** ☐ **NO** ☐

16. **Declaration of Primary State of Residence**: (where I hold a driver's license, pay taxes or vote)

I declare my primary state of residence is _____I plan to primarily practice in the state of_____.

I am in the military or federal government. I am currently licensed in _____ (state) and I do not intend to work outside of military or federal government.

PART II: Education/Professional Education

List in chronological order from date of graduation to the present <u>all</u> professional education. Do not include continuing education coursework or clinical training.

SCHOOL /INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
				Y☐ N☐	
				Y☐ N☐	
				Y☐ N☐	
				Y☐ N☐	

<u>Transcripts</u>: Provide an official transcript sent directly to the board from your master's nursing education program. The application cannot be completely processed until we have the official transcript showing completion of a masters in nursing post masters or doctorate

College or University Accredited? Yes ☐ No ☐ **Graduate Nursing Program Accredited? Yes ☐ No ☐**	**If yes, Accredited by:**

PART III: Record of Examination(s)

Complete the requested information below if licensure examination was taken in this state or any other state. List each examination attempt below. Attach additional sheets if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination	State or Country	Date of Examination	Passed/Failed/Score (If score, enter score)
Specialty Certification Exam(s)	**Certifying Organization(s)**	**Original Date of Certification**	**Expiration Date of Certification**

PART IV: Record of Licensure

Complete the requested information below if you have ever been licensed, certified or registered to practice in any profession or occupation. You must identify the method by which you obtained **your** license(s) and include jurisdiction both within and outside the United States, current or inactive. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

Jurisdiction	Credential Type (LPN, RN or APRN)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date Issued
State of Original (Initial) Licensure:				
List Other Jurisdictions of Licensure:				

PART V: Employment History

List all related employment 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" for Not Applicable. Photocopy this page and attach if additional space is required.

1. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To:
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**
2. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: To:
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**
3. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To:
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**
4. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To:
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
5. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To:
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**

PART VI: Personal History Information

If you answer "**yes"** to any of the questions below (1-10), you must attach a full written explanation pertaining to that particular question.

1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority?	**YES** ☐ **NO** ☐
2. Have you ever been refused or denied the privilege of taking an examination required for any professional license?	**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 have any unresolved or pending complaints ever 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 ever been arrested, charged or convicted (including a nolo contender plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? **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. Currently are you being treated or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
8. Currently or within the last five years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
9. Currently or within the last five years, have you developed any disease or conditions, physical, mental, or emotional that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
10. a. Have you ever voluntarily surrendered a nursing license? b. Have you ever voluntarily surrendered a controlled substance or DEA registration?	**YES**☐ **NO** ☐ **YES**☐ **NO** ☐ **NA**☐
11. a. Do you plan to prescribe Schedules III through V? b. Do you have a controlled substance or DEA registration?	**YES**☐ **NO** ☐ **NA**☐ **YES**☐ **NO** ☐ **NA**☐

PART VII: Specialty Area(s) & Certification(s)

1. Specialty area of APRN practice.

2. Describe your specialty area in advanced nursing practice. **(**This section will be assessed by an Advanced Practice Nursing Consultant who will determine the closest scope of practice area in accordance with National Certification)

3. Do you hold current specialty certification by a national credentialing organization(s)? **YES** ☐ **NO** ☐

Certifying Organization_____

Expiration date_____(Attached a copy of certificate)

Other

Check here if you are trained and willing to volunteer your services during a bioterrorism disaster? **YES** ☐ **NO** ☐

Check here if you are trained and willing to volunteer your services during a disaster? **YES** ☐ **NO** ☐

PART VIII: Advanced Practice Employment (Current)

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)	
Supervising Physician: ☐ Primary Physician ☐ Alternate Supervising Physician	Supervising Physician (All physicians must have a permanent SC license in good standing) Business Address: (Street, City, State, Zip)	Proximity to NP, CNM, CNS in Miles:
SC Physician's License No:	Practice Specialty:	Primary Practice Site Phone Number

_____ _____

Signature of Supervising Physician Date

By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

SECONDARY/ADDITIONAL Practice Site (If more than 2 sites, duplicate form as needed)	Employer Name:	
	Practice Address: (Street, City, State, Zip)	
Supervising Physician: ☐ Primary Physician ☐ Alternate Supervising Physician	Supervising Physician (All physicians must have a permanent SC license in good standing) Business Address: (Street, City, State, Zip)	Proximity to NP, CNM, CNS in Miles:
SC Physician's License No:	Practice Specialty:	Secondary Practice Site Phone Number

_____ _____

Signature of Supervising Physician Date

By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

A copy of practice protocols, for NP, CNM, or CNS/ copy of written approved guidelines for CRNA 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 ☐

PART IX: Certifying Statement

I, _____ (**print name**), am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. 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 act shall constitute the cause for denial or revocation of my license to practice nursing in South Carolina.

I hereby authorize the South Carolina Board of Nursing to utilize my Social Security Number (SSN) in making necessary reports to the National Council of State Boards of Nursing (NCSBN) data center for compilation of information about applicants and licenses 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 (Do not print) Date

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

20_____.

_____

Signature of Notary Public

My Commission Expires: _____

Tape photo at top **only**

Attach recent passport photo here
"2 x 2"
No copies

Sign and date front of photo

Do not staple

DID YOU REMEMBER TO:

- ☐ Complete and answer all questions in ink. Sign, date, and have application notarized. Complete the Affidavit of Eligibility. (Next 2 pages)
- ☐ Sign, date your photo on front and tape onto your application. Black & white photos are acceptable.
- ☐ Submit a copy of your birth certificate or a valid passport. (Copy of hospital birth certificate not accepted)
- ☐ Submit a copy of your current nursing licenses from other states with the expiration date (RN and APRN).
- ☐ Submit a copy of your social security card, permanent resident card or a resident alien identification card.
- ☐ Submit a copy of your marriage license; divorce decree or court document as proof of legal change in name. These documents are part of your file and are not returned.
- ☐ Register with NURSYS if your original state of RN licensure is a member board of NURSYS **or** submit the Verification Form to the board where you took the NCLEX and received your original license if the board is not a member of Nursys. Also, submit the Verification Form to your original state of advanced practice licensure prescriptive authority must be verified (if applicable).
- ☐ Have official transcript sent directly from your master's of nursing educational program to the SC Board of Nursing.
- ☐ Submit a copy of a current advanced practice nursing specialty certification. (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).
- ☐ **Review the SC Nurse Practice Act and Medical Practice Act for guidelines on the development of written protocols.**
- ☐ Obtain all SC physician signatures and license numbers to be included on your application, if applicable.
- ☐ Submit 45 hours of pharmacotherapeutics of which 15 hours must be in controlled substances (initial applicants) or 20 hours of pharmacotherapeutics of which 15 hours must be in controlled substances (applicants licensed in another state with prescriptive authority). Signatures of SC supervising physicians are necessary before prescriptive authority is added to your license. Approved controlled substance courses can be found at http://academicdepartments.musc.edu/chp/pa/cme/pac.htm and http://ahecu.mrooms3.net/.
- ☐ Enclose a non-refundable fee - Money order, cashier's check or personal check made payable to **LLR-Board of Nursing.**
  - $130.00 – Permanent license only.
  - $140.00 – Temporary license & permanent license.

- ☐ Criminal Background Check (CBC): Board will forward instructions once application is received.
- ☐ **Check the status of your application online at www.llr.state.sc.us/pol/nursing.** Once all requirements have been received, a license number may be generated within 10 business days. During peak times, the application review/approval process may take longer.

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)

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.)

being first duly sworn deposes and states as follows:

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 _____

_____

Notary Public for _____

My Commission Expires: _____

I

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-688)
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)

NURSYS ONLINE VERIFICATION INSTRUCTIONS

1. If your original state of RN licensure is NOT one of the states listed below, **DO NOT** attempt to verify your license at https:\\www.nursys.com. Instead, follow the verification instructions on the South Carolina Board of Nursing verification form.

Alaska	Maryland	New York
Arkansas	Maine	Ohio
American Samoa	Michigan	Oregon
Arizona	Minnesota	Rhode Island
Colorado	Missouri	South Dakota
District of Columbia	Northern Mariana	Tennessee
Delaware	Islands	Texas
Florida	Mississippi	Utah
Guam	Montana	Virginia
Iowa	North Carolina	Virgin Islands
Idaho	Nebraska	Vermont
Indiana	New Hampshire	Washington
Kentucky	New Jersey	Wisconsin
Louisiana-RN	New Mexico	West Virginia-PN
Massachusetts	Nevada	Wyoming

NURSYS Secure Online Verification Process: https:\\www.nursys.com

South Carolina Board of Nursing Verification Form

Use this form ONLY if your original state of RN licensure is NOT listed on the preceding page (Nursys page). Use this form to verify your original state of advanced practice licensure (make copies as necessary). Most states charge a fee to complete this form. Check with each state board before mailing this form.

PART I: To be completed by the applicant and **forwarded to the original state of licensure with applicable fee.**

Name_____
First Middle Maiden Last

Previous Names(s)_____

Current Street Address_____City_____ State__ Zip_____

Date of Birth_____(mm/dd/yyyy) Social Security # _____

Nursing Education Program_____Degree Granted_____

Nam as on original license_____
First Middle Maiden Last

City of Program_____ State_____Date of Completion_____

Original State of Licensure_____Issue Date of Original License_____ Original License Number_____

Type of License: APRN_____ RN_____ Current State of Licensure_____ Issue Date of Current License_____

Current License Number_____Type of License APRN_____ RN_____

LIST ALL OTHER STATES OF LICENSURE

State:_____ License Number:_____ Date Issued:_____

State:_____ License Number:_____ Date Issued:_____

State:_____ License Number:_____ Date Issued:_____

I hereby authorize all identified Boards of Nursing to release my licensure data to the South Carolina Board of Nursing.

Signature_____ Date_____

PART II: To be completed by the original state of licensure and forwarded to:

South Carolina Board of Nursing, P. O. Box 12367, Columbia, SC 29211

This is to certify that_____ was issued license number_____ Date Issued_____
(Applicant Name)
to practice as a(n) APRN_____RN _____ Prescriptive authority Issued: _____ Are prescriptive rights still active? ☐Yes No ☐

Licensed by: Examination_____ Endorsement_____ Waiver/Equivalency_____

Current Licensure Status: Active_____ Inactive_____ Lapsed_____ Expiration Date:_____

Has this license ever been encumbered (denied, revoked, suspended, limited, placed on probation)? ☐Yes No☐
Disciplinary Action Pending? Explain yes responses and/or attach a certified copy of the action. ☐Yes No☐

Nursing Education Program Completed_____Approved by State? ☐Yes No☐

Location (city/state)_____Graduation Date_____

Type of Nursing Program DIP_____ ADN_____ BSN_____ Master's_____Other_____

STATE BOARD TEST POOL EXAMINATION___ RN_____LP/VN _____NCLEX_____RN___LP/VN_____

Scores : Medical Nursing____Psychiatric Nursing_____Obstetric Nursing___Surgical Nursing_Nursing of Children_____

Series/Form_____Number of times applicant took exam_____Exam Dates:_____

Signature_____Title_____State_____Date_____