Advanced Practice Registered Nurse (APRN) – Certified Registered Nurse Anesthetist (CRNA)

Change of Practice Request Form

(§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.

Last Name	First Name	Middle Name	Maiden Name

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

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

Nature of Change:

☐ New Employment ☐ Change of Practice Site(s) ☐ Change of Physician/Dentist

☐ Additional Practice Site(s) ☐ Other (specify): _____

☐ Removal of Physician/Dentist 1._____ Lic. #_____ 2._____ 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)
* Supervising Physician/Dentist: (of written guidelines) ☐ Physician ☐ Dentist ☐ Medical Director	Supervising Physician/Dentist of Written Guidelines (Must have a permanent SC license in good standing)
	Business Address: (Street, City, State, Zip)
SC Physician/Dentist's License No:	Primary Practice Site Phone Number

SUPERVISING 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 Supervising Physician/Dentist*: **Date:**

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)
* Supervising Physician/Dentist: (of written guidelines) ☐ Physician ☐ Dentist ☐ Medical	Supervising Physician/Dentist of Written Guidelines (Must have a permanent SC license in good standing)
	Business Address: (Street, City, State, Zip)
SC Physician/Dentist's License No:	Secondary Practice Site Phone Number

SUPERVISING 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 Supervising Physician/Dentist*: **Date:**

A copy of written approved guidelines signed and dated by the physician/dentist 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**