South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
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EMPLOYER CERTIFICATION

This form is for an employer to submit as verification of **continued competency** and nursing practice hours worked.

Applicant/Licensee/Employee Name (Print): _____

I hereby authorize you, the employer, to release this information to the South Carolina Board of Nursing. The below requested information for verification must have taken place within the past two years.

Applicant/Licensee/Employee Signature: _____ Date: _____

Purpose (Check one): ☐ Initial Licensure ☐ Reinstatement/Reactivation ☐ Renewal

EMPLOYER VERIFICATION SECTION

'Competence' (defined in the SC Nurse Practice Act sections 40-33-20 (21)) means the ability of a licensed nurse to perform safely, skillfully, and proficiently the functions within the role of the licensee. The role encompasses the possession and interrelation of essential knowledge, judgment, attitudes, values, skills, and abilities, which are varied and range in complexity. Competence is a dynamic concept, changing as the licensed nurse achieves a higher stage of development, responsibility, and accountability within the role.

Do not include orientation period/hours worked.

CERTIFICATION:

By signing this form, I certify _____, has worked an acceptable amount of practice hours during the period of _____ to _____, and verify they meet the continued competency needed to perform their job function as defined by the SC Nurse Practice Act sections 40-33-20 (21).

_____
Employer/Representative Signature

EMPLOYER INFORMATION

Company Name: _____ Date: _____

Employer/Representative Name: _____ Title: _____

Email Address: _____ Phone: _____