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
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llr.sc.gov/nurse

# REQUIREMENTS AND INSTRUCTIONS FOR APRN PRESCRIPTION AUTHORITY APPLICATION

A Nurse Practitioner (NP), Certified Nurse-Midwife (CNM), or Clinical Nurse Specialist (CNS) who applies for prescriptive authority must comply with the following requirements pursuant to South Carolina Code Section 40-33-34(E)(1), by submitting the following:

**Initial Prescriptive Authority Applicant**
After obtaining a SC nurse practitioner, certified nurse mid-wife, or clinical nurse specialist license, a prescriptive authority application may be completed with the following requirement(s):

- Provide evidence of completion of forty-five (45) contact hours of education in pharmacotherapeutics acceptable to the board, within two (2) years before application. At least fifteen (15) hours of the forty-five (45) hours should be of education in controlled substances.
    - New graduates (graduated within two (2) years before the application) who have completed a graduate level pharmacology course meet the educational requirements for prescriptive authority and controlled substances.
      **Note:** If your official college transcript was provided with your initial application, you do not need to send in another transcript.

**Endorsement Applicant with Existing Out-of-State Prescriptive Authority**
(Has an existing out-of-state prescriptive authority license.)
After obtaining a SC nurse practitioner, certified nurse mid-wife, or clinical nurse specialist license, a prescriptive authority application may be completed with the following requirement(s):

- a current state-issued license verification or a current DEA registration that reflects current prescriptive authority licensure;
- proof of twenty (20) contact hours in pharmacotherapeutics within two (2) years before application. At least fifteen (15) of the twenty (20) hours should be in controlled substances.

**Requirements for Reactivating/Reinstating Prescriptive Authority**

- Applicants whose privileges have lapsed for less than six (6) months do not require additional contact hours.
- Applicants whose privileges have lapsed for more than six (6) months or who previously held prescriptive authority in another state whose privileges in that state have expired by more than six (6) months, must meet the requirements of a first time applicant (see Initial prescriptive authority).

**Board Approved Listing for Pharmacotherapeutics Education:**
https://llr.sc.gov/nurse/PDF/Board_Approved_Listing_for_Pharmacotherapeutics_Education.pdf

Additional required documentation:

- APRN Change of Practice Form

Apply online at https://apply.llr.sc.gov/.

**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) – 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.**

**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**<br>**(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**<br>☐ **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 S.C. CODE SECTION 40-47-195.**

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-195.

**Signature of Collaborating Physician:** **Date**

| **SECONDARY/ADDITIONAL Practice Site**<br>**(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**<br>☐ **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 40-47-195.**

By signing this document, I affirm that I understand the limitations imposed upon physicians as set forth in S.C. Code section 40-47-195.

**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**