



South Carolina  
Department of Labor, Licensing and Regulation

Board of Medical Examiners

Henry D. McMaster  
Governor

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The physician late renewal process is statutory. See SC Code 40-47-43 below.

Online Renewal is not available after midnight June 30, 2017.

LATE RENEWAL CHECKLIST

\_\_\_ COMPLETED PAPER RENEWAL APPLICATION WITH ALL QUESTIONS ANSWERED AND SIGNED. YES ANSWERS MUST BE FULLY EXPLAINED.

\_\_\_ \$155.00 RENEWAL FEE

\_\_\_ \$100.00/MONTH LATE FEE

\_\_\_ ATTACH ALL CME CERTIFICATES OR TRANSCRIPT UNLESS FIRST RENEWAL. [40 TOTAL-30 SPECIALTY, 10 MAY BE NON SPECIALTY, 2 HOURS MUST BE IN SAFE PRESCRIBING AND MONITORING OF CONTROLLED SUBSTANCES. ALL MUST BE AMA/AOA CATEGORY 1 TAKEN BETWEEN 7/1/15 AND 6/30/17. MAY CLAIM UP TO 10 HOURS FOR VOLUNTEER SERVICE.

\_\_\_ PRACTICE STATEMENT: MUST BE COMPLETED AND NOTARIZED. IF PRACTICE OCCURRED WITH AN EXPIRED LICENSE, INCLUDE \$1000.00/MONTH PENALTY FOR UNAUTHORIZED PRACTICE.

**SECTION 40-47-43. Renewal of expired license.**

A person submitting an application for renewal within one year after the expiration of the previous authorization period shall:

- (1) submit a completed application on a form provided by the board;
- (2) pay a renewal fee;
- (3) pay a late fee of one hundred dollars for any part of each month during which the license was lapsed;
- (4) provide evidence of compliance with applicable continued competency requirements; and

(5) provide a statement under oath relating any practice activity following the expiration of the previous renewal period. If unauthorized practice occurred following the expiration of the previous renewal period, a penalty of one thousand dollars must be imposed for any portion of each month in which unauthorized practice occurred. The penalty must be paid in full before the license may be renewed by the department unless otherwise provided by the board.

HISTORY: 2006 Act No. 385, Section 1.



**South Carolina Department of Labor, Licensing and Regulation  
South Carolina Board of Medical Examiners**

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2017 – 2019 Renewal Application for: \_\_\_\_\_ License #: \_\_\_\_\_

**Renewal Instructions**

1. Complete all questions, blank spaces, and **sign and date application on back of form. Incomplete applications will be returned.**
2. **Mail completed application with a payment of \$155.00 made payable to LLR-Board of Medical Examiners.** Applications must be postmarked by the Post Office on or before June 30, 2017.
3. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.
4. All fees are non-refundable.

Home Address	Primary Place of Employment	Mailing Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

County: _____	County: _____
Phone: _____	Phone: _____
Email: _____	Fax: _____
Cell Phone: _____ (Confidential Info for DHEC Emergency Contact System)	Email: _____
Home Congressional District: _____	Hrs./Wk: _____

**Contact your voter registration office to obtain congressional district information. Failure to provide this information will render your application incomplete, causing delays and possible penalties.**

Type of Practice: \_\_\_\_\_

SC Activity Status (Check one only) Currently on File: \_\_\_\_\_

- 01 Currently practicing Medicine     02 Temp not practicing Medicine     08 Retired

Primary Practice Setting (Where patients are seen initially) Currently on File:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> 44 Admin/Regulatory Hlth Agency  | <input type="checkbox"/> 22 Fed Non-Military Hlth Facility  | <input type="checkbox"/> 11 Hosp, Non-Fed General     | <input type="checkbox"/> 15 Private Office       |
| <input type="checkbox"/> 50 Business Establishment        | <input type="checkbox"/> 27 Free-Standing Amb Surgery Ctr   | <input type="checkbox"/> 23 Hosp, Non-Fed Psy         | <input type="checkbox"/> 31 Univ/College of Med  |
| <input type="checkbox"/> 20 Comm Hlth Ctr, Rural Hlth Cln | <input type="checkbox"/> 13 Free-Standing Clinic            | <input type="checkbox"/> 24 Hospital, Non-Fed Rehab   | <input type="checkbox"/> 71 Other specify: _____ |
| <input type="checkbox"/> 21 Fed Military Hlth Facility    | <input type="checkbox"/> 29 Free-Standing Emerg/Urgent Care | <input type="checkbox"/> 14 Outpat Mental Hlth Clinic | _____  |

Form of Practice (Source of Income) Currently on File:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> 32 County Gov                 | <input type="checkbox"/> 28 Non-profit Hlth Agency   | <input type="checkbox"/> 11 Self, Solo                   | <input type="checkbox"/> 33 State Gov            |
| <input type="checkbox"/> 34 Fed Civilian (Incl. USPHS) | <input type="checkbox"/> 25 Other Private Emp        | <input type="checkbox"/> 13 Self, Group, Same Specialty  | <input type="checkbox"/> 44 Volunteer            |
| <input type="checkbox"/> 35 Fed Military               | <input type="checkbox"/> 43 Resident/Intern Training | <input type="checkbox"/> 14 Self, Group, Multi-Specialty | <input type="checkbox"/> 42 Other specify: _____ |

Information on file is pre-printed. Make changes in the shaded blocks.

Hours Per Week Spent In:

Total	Patient Care	Administration	Teaching	Research	Training	Other

Hours per Week Spent in Specialties (Should add to total hours above):

Primary Specialty	Hrs./Wk.	Secondary Specialty	Hrs./Wk.	Tertiary Specialty	Hrs./Wk.

**Secondary Locations of Practice in S.C.**

1.	City	County	Specialty	Setting	Hrs./Wk.
2.	City	County	Specialty	Setting	Hrs./Wk.

Indicate all South Carolina hospital affiliations, which you presently have:

1.
2.
3.

1. Please check this box if you are willing for your name to be added to a list of volunteer physicians who may be called upon in the event of a public health emergency.

Answer "Yes" or "No" to each of the following questions. If your answer is "Yes" to questions 2-8, below, you must attach a full written explanation.

- 2. Since your last renewal, has any Order or other disciplinary action been rendered against you by any Medical Board (other than SC Board) or have you been denied licensure by any other Medical Board?  Yes  No
- 3. Since your last renewal, have any hospital privileges or other privileges of any kind been revoked, suspended, restricted, denied, voluntarily surrendered or relinquished? (Include the relinquishment of privileges while under investigation or pending action for any reason. Do not include the relinquishment of privileges as a result of a personal decision.)  Yes  No
- 4. Since your last renewal, has your ability to practice medicine been impaired by any physical, emotional or mental illness, whether temporary or permanent?  Yes  No
- 5. Since your last renewal, have you been treated for any physical, mental, or emotional conditions that might interfere with your ability to competently and safely perform the essential functions of practice?  Yes  No
- 6. Since your last renewal, have you developed any disease or conditions, physical, mental or emotional (i.e. bipolar disease, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice? (If you have voluntarily enrolled in Recovering Professionals Program (RPP) and have remained in full compliance, you may answer "No")  Yes  No
- 7. Since your last renewal, have you been convicted or pled guilty or pled *nolo contendere* for violation of any federal, state or local law (other than minor traffic violations)?  Yes  No
- 8. Since your last renewal, have you voluntarily restricted or curtailed your practice other than for retirement, family leave or vacation?  Yes  No
- 9. Are you currently in residency training?  Yes  No
- 10. Have you changed specialty since your last renewal?  Yes  No
- 11. Do you supervise procedures involving the use of devices such as lasers, intense pulse light (IPL), microwaves, infrared, etc.? If so, which procedures do you delegate to others?  Yes  No
- 12. Has there been any change in the status of your lawful presence in the United States since initial licensure? If yes, attach supporting documentation.  Yes  No

**Continuing Education**

- 13. Continuing Education: Since your last renewal, have you documented evidence of continued competency? You may answer 'YES' if this is your first renewal after initial permanent licensure.  Yes  No
- 14. Continuing Education: Have you documented evidence of completion of two (2) Category 1 CME hours in approved procedures of prescribing and monitoring controlled substances? You may answer 'YES' if this is your first renewal after initial permanent licensure.  Yes  No

I have carefully read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina license and rejection of this application or delay in processing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If your name has changed, please provide the Board with a copy legal documents showing the change. After June 30, 2017, your license will lapse and be subject to a \$100 per month late fee. S.C. Code Section 40-47-41 states in part "...A licensee shall notify the board in writing within fifteen business days of any change of residential address, office address, or office telephone number."

*South Carolina Law requires the agency collect personal information which is only disseminated as required by law. 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 your renewal application and other documents on file, 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. In order to better protect the information you provide, please provide the Department with the following information that may be released to the public upon request: a public mailing address, a public email address and a public telephone number.*

**PRACTICE ACTIVITY STATEMENT MADE PURSUANT TO S.C. CODE 40-47-43**

**This form must be notarized**

PRINTED FULL NAME OF LICENSEE \_\_\_\_\_

LICENSE NUMBER \_\_\_\_\_ M.D. or D.O. [Circle one]

1. I UNDERSTAND THIS IS A SWORN STATEMENT MADE UNDER OATH \_\_\_\_\_ [initial of licensee]
2. I HEREBY CERTIFY THAT I
  - a. \_\_\_\_\_ HAVE **NOT** PRACTICED MEDICINE SINCE THE LAPSE OF MY SOUTH CAROLINA MEDICAL LICENSE ON JUNE 30<sup>th</sup>, 2017.
  - b. \_\_\_\_\_ HAVE PRACTICED MEDICINE SINCE THE LAPSE OF MY SOUTH CAROLINA MEDICAL LICENSE ON JUNE 30<sup>th</sup>, 2017.

Signature of Licensee \_\_\_\_\_ DATE \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2017

Notary Public Signature \_\_\_\_\_

My Commission Expires \_\_\_\_\_

Practice of Medicine is defined at SC Code 40-47-20 (36) (36) "Practice of Medicine" means:

- (a) advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in this State;
- (b) offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person;
- (c) offering or undertaking to prevent or to diagnose, correct or treat in any manner, or by any means, methods, or devices, disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of a person, including the management or pregnancy and parturition;
- (d) offering or undertaking to perform any surgical operation upon a person;
- (e) rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within this State by a physician located outside the State as a result of transmission of individual patient data by electronic or other means from within a state to such physician or his or her agent;
- (f) rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient is the practice of medicine subject to all of the powers provided to the Board of Medical Examiners, except as provided in Section 38-59-25;
- (g) using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination of these in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in this State that is applicable to the clinical setting.