CHAPTER 47

Physicians and Miscellaneous Health Care Professionals

ARTICLE 1

General Provisions

**SECTION 40‑47‑5.** Application of Chapter 1; conflict with other articles.

(A) Unless otherwise provided for in this chapter, Chapter 1, Title 40 applies to the profession or business regulated under this chapter. However, if there is a conflict between this chapter and Article 1, Chapter 1, Title 40, the provisions of this chapter control.

(B) Unless there is a conflict with other articles of this chapter, Article 1, Chapter 47, Title 40 applies to all programs administered through the State Board of Medical Examiners.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

Prior Laws:1985 Act No. 93, Section 6.

**SECTION 40‑47‑10.** State Board of Medical Examiners; appointment; terms and vacancies; powers and duties.

(A)(1) There is created the State Board of Medical Examiners to be composed of thirteen members, three of whom must be lay members, one of whom must be a doctor of osteopathic medicine, two of whom must be physicians from the State at large, and seven of whom must be physicians, each representing one of the seven congressional districts. All members of the board must be residents of this State, and each member representing a congressional district shall reside in the district the member represents. All physician members of the board must be licensed by the board, must be without prior disciplinary action or conviction of a felony or other crime of moral turpitude, and must be practicing their profession in this State. All lay members of the board must hold a baccalaureate degree or higher, must not have been convicted of a felony or a crime of moral turpitude, and must not be employed or have a member of their immediate family employed in a health or medically related field.

(2) The members of the board shall serve for terms of four years or until their successors are appointed and qualify. Members of the board may only serve three consecutive terms.

(3) All members of the board have full voting rights.

(4) The one lay member and one physician from the State at large must be appointed by the Governor, with the advice and consent of the Senate. Two lay members must be appointed by the Governor, with the advice and consent of the Senate, one upon the recommendation of the President Pro Tempore of the Senate and one upon the recommendation of the Speaker of the House of Representatives.

(5) The board shall conduct an election to nominate one physician from the State at large. The election must provide for participation by all physicians currently permanently licensed and residing in South Carolina. To nominate the physicians who will represent the seven congressional districts, the board shall conduct an election within each district. These elections must provide for participation by all permanently licensed physicians residing in the particular district. The board shall conduct an election to nominate the doctor of osteopathic medicine from the State at large, and this election must provide for participation by any physician currently permanently licensed in this State as a doctor of osteopathic medicine. The board shall certify in writing to the Governor the results of each election. The Governor may reject any or all of the nominees upon satisfactory showing of the unfitness of those rejected. If the Governor declines to appoint any of the nominees submitted, additional nominees must be submitted in the same manner following another election. Vacancies must be filled in the same manner of the original appointment for the unexpired portion of the term.

(6) Vacancies that occur when the General Assembly is not in session may be filled by an interim appointment of the Governor in the manner provided by Section 1‑3‑210.

(B) Public and lay members of boards and panels must be appointed in accordance with Section 40‑1‑45.

(C) Board members and persons authorized by the board to engage in business for the board must be compensated for their services at the usual rate for mileage, subsistence, and per diem as provided by law for members of state boards, committees, and commissions and may be reimbursed for actual and necessary expenses incurred in connection with and as a result of their work as members or persons acting on behalf of the board.

(D) The board annually shall elect from among its members a chairman, vice chairman, secretary, and other officers as the board determines necessary. The board may promulgate regulations reasonably necessary for the performance of its duties and the governance of its operations and proceedings, for the practice of medicine, for judging the professional and ethical competence of physicians, including a code of medical ethics, and for the discipline of persons licensed or otherwise authorized to practice pursuant to this chapter.

(E) The board shall meet at least four times a year and at other times upon the call of the chair or a majority of the board.

(F) A majority of the members of the board constitutes a quorum; however, if there is a vacancy on the board, a majority of the members serving constitutes a quorum.

(G) A board member is required to attend meetings or to provide proper notice and justification of inability to do so. The Governor may remove members from the board for absenteeism, as well as for other grounds provided for in Section 1‑3‑240.

(H) The Chairman of the State Board of Medical Examiners, or the chairman’s designee, shall serve as an advisory nonvoting member of the State Board of Nursing to provide consultation on matters requested by the State Board of Nursing. The Board of Nursing shall send written notice at least ten days before meetings that the Board of Nursing wants the Chairman of the State Board of Medical Examiners, or the chairman’s designee, to attend. The Chairman of the State Board of Medical Examiners, or the chairman’s designee, and the State Board of Nursing shall meet at least twice a year and more often as necessary.

(I) In addition to the powers and duties enumerated in Section 40‑1‑70, the board may:

(1) publish advisory opinions and position statements relating to practice procedures or policies authorized or acquiesced to by any agency, facility, institution, or other organization that employs persons authorized to practice under this chapter to comply with acceptable standards of practice;

(2) develop minimum standards for continued competency of licensees continuing in or returning to practice;

(3) adopt rules governing the proceedings of the board and may promulgate regulations for the practice of medicine and as necessary to carry out the provisions of this chapter;

(4) conduct hearings concerning alleged violations of this chapter;

(5) use minimum standards as a basis for evaluating safe and effective medical practice;

(6) license and renew the authorizations to practice of qualified applicants;

(7) approve temporary licenses, limited licenses, and other authorizations to practice in its discretion as it considers in the public interest;

(8) join organizations that develop and regulate the national medical licensure examinations and promote the improvement of the practice of medicine for the protection of the public;

(9) collect any information the board considers necessary, including social security numbers or alien identification numbers, in order to report disciplinary actions to national databanks of disciplinary information as otherwise required by law;

(10) establish guidelines to assist employers of licensees when errors in practice can be handled through corrective action in the employment setting.

HISTORY: 2006 Act No. 385, Section 1; 2012 Act No. 222, Section 8, eff June 7, 2012.

Editor’s Note

Prior Laws:1904 (24) 513; Civ. C. ‘12 Section 1619; 1920 (31) 1004; Civ. C. ‘22 Section 2401; 1932 Code Section 5151; 1942 Code Section 5151; 1952 Code Section 56‑1351; 1962 Code Section 56‑1351; 1969 (56) 754; 1970 (56) 2371; 1981 Act No. 116, Sections 2, 3; 1985 Act No. 93, Section 2; 1993 Act No. 77, Section 1; 2005 Act No. 171, Section 1.

2012 Act No. 222, Section 15, provides as follows:

“SECTION 15. Notwithstanding any other provision of law to the contrary, any person elected or appointed to serve, or serving, as a member of any board, commission, or committee to represent a congressional district, whose residency is transferred to another district by a change in the composition of the district, may serve, or continue to serve, the term of office for which he was elected or appointed; however, the appointing or electing authority shall appoint or elect an additional member on that board, commission, or committee from the district which loses a resident member on it as a result of the transfer to serve until the term of the transferred member expires. When a vacancy occurs in the district to which a member has been transferred, the vacancy must not be filled until the full term of the transferred member expires.”

Effect of Amendment

The 2012 amendment in subsection (A)(1), substituted “thirteen” for “twelve”, and twice substituted “seven” for “six”; in subsection (A)(5), substituted “seven” for “six”; in subsection (D), substituted “promulgate regulations” for “adopt rules and regulations”; and deleted subsection (I)(11), relating to regulations for initial fee schedule.

**SECTION 40‑47‑11.** Medical Disciplinary Commission; qualifications of members; hearings; service as expert witnesses.

(A) There is created the Medical Disciplinary Commission of the State Board of Medical Examiners to be composed of thirty‑five physician members appointed by the board and seven lay members appointed by the Governor. The physician members of the commission must be licensed physicians practicing their profession, and they must be without prior disciplinary action or conviction of a felony or other crime of moral turpitude. Five physician commissioners must be appointed from each of the seven congressional districts and must reside in the district, which they are appointed to represent. The members of the commission are limited to three consecutive terms. A member of the Board of Medical Examiners may not simultaneously serve as a commissioner. In case of a vacancy by way of death, resignation, or otherwise, the board shall appoint a successor to serve for the unexpired portion of the term. Where justice, fairness, or other circumstances so require, the board may appoint past commissioners to hear complaints in individual cases.

(B) All lay commissioners must hold a baccalaureate degree or higher, must not have been convicted of a felony or other crime of moral turpitude, and must not be employed or have a member of their immediate family employed in a health or medically related field. One lay commissioner must be appointed by the Governor from each of the seven congressional districts, with the advice and consent of the Senate. Each lay commissioner must be a registered voter and reside in the congressional district he represents throughout his term. Each lay commissioner initially appointed from each district shall serve for a term of three years and until his successor is appointed and qualified. Vacancies must be filled in the manner of the original appointment for the remainder of the unexpired portion of the term. The Governor may appoint a lay commissioner to serve a full term; however, a lay commissioner may not serve more than three consecutive terms.

(C) The commission is empowered to hear those formal complaints filed against practitioners authorized to practice under this chapter, unless otherwise provided in this chapter. These hearings must be conducted in accordance with the Administrative Procedures Act and with regulations promulgated by the Board of Medical Examiners and must be before a panel composed of not more than three physician commissioners and one lay commissioner. The panel is empowered to hear the matters complained of and to recommend findings of fact and conclusions of law to the board. The panel shall submit a certified report of its proceedings, including its findings of fact, conclusions of law, and mitigating and aggravating circumstances, for consideration by the board in rendering a final decision and shall file this report with the department.

(D) The physician members of the commission may serve as expert reviewers and witnesses in investigations and proceedings pursuant to this chapter. A physician commissioner who serves as an expert reviewer or witness in an investigation or proceeding may not serve on the hearing panel for that particular matter or related matters.

HISTORY: 2006 Act No. 385, Section 1; 2012 Act No. 222, Section 9, eff June 7, 2012.

Editor’s Note

2012 Act No. 222, Section 15, provides as follows:

“SECTION 15. Notwithstanding any other provision of law to the contrary, any person elected or appointed to serve, or serving, as a member of any board, commission, or committee to represent a congressional district, whose residency is transferred to another district by a change in the composition of the district, may serve, or continue to serve, the term of office for which he was elected or appointed; however, the appointing or electing authority shall appoint or elect an additional member on that board, commission, or committee from the district which loses a resident member on it as a result of the transfer to serve until the term of the transferred member expires. When a vacancy occurs in the district to which a member has been transferred, the vacancy must not be filled until the full term of the transferred member expires.”

Effect of Amendment

The 2012 amendment rewrote subsection (A); substituted “One” for “Two”, “commissioner” for “commissioners”, and “seven” for “six” in subsection (B); and, inserted “of Medical Examiners” in subsection (C).

**SECTION 40‑47‑20.** Definitions.

In addition to the definitions provided in Section 40‑1‑20, as used in this chapter unless the context indicates otherwise:

(1) “Active license” means the status of an authorization to practice that has been renewed for the current period and authorizes the licensee to practice in this State.

(2) “Administrative hearing officer” means a physician designated by the board or director.

(3) “Adverse disciplinary action” means a final decision by a United States or foreign licensing jurisdiction, a peer review group, a health care institution, a professional or medical society or association, or a court, which action was not resolved completely in the licensee’s favor.

(4) “Agreed to jointly” means the agreement by the Board of Nursing and Board of Medical Examiners on delegated medical acts that nurses perform and that are promulgated by the Board of Nursing in regulation.

(5) “Approved written protocols” means specific statements developed collaboratively by the physician or the medical staff and the advanced practice registered nurse (NP, CNM, or CNS) that establish physician delegation for medical aspects of care, including the prescription of medications.

(6) “Approved written scope of practice guidelines” means specific statements developed by a physician or the medical staff and a physician assistant that establish physician delegation for medical aspects of care, including the prescription of medications.

(7) “Board” means the State Board of Medical Examiners for South Carolina.

(8) “Board‑approved credentialing organization” means an organization that offers a certification examination in a specialty area of practice, establishes scope and standards of practice statements, and provides a mechanism approved by the board for evaluating continuing competency in a specialized area of practice.

(9) “Business days” means every day except Saturdays, Sundays, and legal holidays.

(10) “Cancellation” means the withdrawal or invalidation of an authorization to practice that was issued to an ineligible person either in error or based upon a false, fraudulent, or deceptive representation in the application process.

(11) “Certification” means approval by an established body, other than the board, but recognized by the board, that recognizes the unique, minimal requirements of specialized areas of practice. Certification requires completion of a recognized formal program of study and specialty board examination, if the specialty board exists, and certification of competence in practice by the certifying agency.

(12) “Criminal history” means a federal, state, or local criminal history of conviction or a pending charge or indictment of a crime, whether a misdemeanor or a felony, that bears upon a person’s fitness or suitability for an authorization to practice with responsibility for the safety and well‑being of others.

(13) “Delegated medical acts” means additional acts delegated by a physician or dentist to a physician assistant, respiratory care practitioner, anesthesiologist’s assistant, or other practitioner authorized by law under approved written scope of practice guidelines or approved written protocols as provided by law in accordance with the applicable scope of professional practice. Delegated medical acts must be performed under the supervision of a physician or dentist who must be readily or immediately available for consultation in accordance with the applicable scope of professional practice.

(14) “Delegated medical acts to the APRN” means additional acts delegated by a physician or dentist to the Advanced Practice Registered Nurse (NP, CNM, or CNS) which may include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy, under approved written protocols as provided in Section 40‑33‑34 and Section 40‑47‑195. Delegated medical acts to the APRN (NP, CNM, or CNS) must be agreed to jointly by both the Board of Nursing and the Board of Medical Examiners. Delegated medical acts to the APRN (NP, CNM, or CNS) must be performed under the general supervision of a physician or dentist who must be readily available for consultation.

(15) “Dentist” means a dentist licensed by the South Carolina Board of Dentistry.

(16) “Disciplinary action” means a final decision and sanction imposed at the conclusion of a disciplinary proceeding.

(17) “Entity” means a sole proprietorship, partnership, limited liability partnership, limited liability corporation, association, joint venture, cooperative, company, corporation, or other public or private legal entity authorized by law.

(18) “Final decision” means an order of the board that concludes a license application proceeding or formal disciplinary proceeding.

(19) “Formal complaint” means a formal written complaint charging misconduct by a respondent in violation of this chapter, Chapter 1 of Title 40, or any other provision of law.

(20) “Immediately available” for the purpose of supervising unlicensed personnel means being located within the office and ready for immediate utilization when needed.

(21) “Inactive license” means the official temporary retirement of a person’s authorization to practice upon the person’s notice to the board that the person does not wish to practice.

(22) “Incompetence” means the failure of a licensee to demonstrate and apply the knowledge, skill, and care that is ordinarily possessed and exercised by other practitioners of the same licensure status and required by the generally accepted standards of the profession. Charges of incompetence may be based upon a single act of incompetence or upon a course of conduct or series of acts or omissions that extend over a period of time and that, taken as a whole, demonstrate incompetence. It is not necessary to show that actual harm resulted from the act or omission or series of acts or omissions if the conduct is such that harm could have resulted to the patient or to the public from the act or omission or series of acts or omissions.

(23) “Independent credentials verification organization” means an entity approved by the board to provide primary source verification of an applicant’s identity, medical education, postgraduate training, examination history, disciplinary history, and other core information required for licensure in this State.

(24) “Initial complaint” means a brief statement that alleges misconduct on the part of a licensee.

(25) “Initial licensure” means the first authorization to practice issued to a person by a licensing authority in this State or any other state.

(26) “Lapsed license” means an authorization to practice that no longer authorizes practice in this State due to the person’s failure to renew the authorization within the renewal period.

(27) “Letter of caution or concern” means a written caution or warning about past or future conduct issued when it is determined that no misconduct has been committed. The issuance of a letter of caution or concern is not a form of discipline and does not constitute a finding of misconduct. The fact that a letter of caution or concern has been issued must not be considered in a subsequent disciplinary proceeding against a person authorized to practice unless the caution or warning contained in the letter of caution or concern is relevant to the misconduct alleged in the proceedings.

(28) “License” means a current document authorizing a person to practice.

(29) “Licensed in good standing” means that one’s authorization to practice has not been revoked and there are no restrictions or limitations currently in effect. Public reprimands issued less than five years from the date an application is received by the board are considered restrictions upon practice.

(30) “Limited license” means a current time‑limited and practice‑limited document that authorizes practice at the level for which one is seeking licensure.

(31) “Misconduct” means violation of any of the provisions of this chapter or regulations promulgated by the board pursuant to this chapter or violation of any of the principles of ethics as adopted by the board or incompetence or unprofessional conduct.

(32) “Osteopathic medicine” means a complete school of medicine and surgery utilizing all methods of diagnosis and treatment in health and disease and placing special emphasis on the interrelationship of the musculo‑skeletal system to all other body systems.

(33) “Pending disciplinary action” means an action or proceeding initiated by a formal complaint.

(34) “Person” means a natural person, male or female.

(35) “Physician” means a doctor of medicine or doctor of osteopathic medicine licensed by the South Carolina Board of Medical Examiners.

(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; and

(h) testifying as a physician in an administrative, civil, or criminal proceeding in this State by expressing an expert medical opinion.

(37) “Practitioner” means a person who has been issued an authorization to practice in this State. The term does not include persons who have not been issued a license, registration, certification, or other authorization to practice in this State, except as provided by law for persons licensed in another state or jurisdiction.

(38) “Presiding officer” means the chairman of the hearing panel or a designee. When no chair of the hearing panel has been designated, the term includes the chairman or vice chairman of the board or a designee. A person designated to act on behalf of the chairman of the board or a hearing panel may not have been involved with the investigation or prosecution of the particular matter.

(39) “Private reprimand” means a statement by the board that misconduct was committed by a person authorized to practice which has been declared confidential and which is not subject to disclosure as a public document.

(40) “Probation” means the issuance of an authorization to practice conditioned upon compliance with terms and conditions imposed by a licensing board in this State or another state. The holder of the authorization to practice on probation may petition the board for reinstatement to full, unrestricted practice upon compliance with all terms and conditions imposed by the board.

(41) “Public reprimand” means a publicly available statement of the board that misconduct was committed by a person authorized to practice.

(42) “Reactivation” means the restoration to active status of an authorization from inactive status.

(43) “Readily available” means the physician must be in near proximity and is able to be contacted either in person or by telecommunications or other electronic means to provide consultation and advice to the practitioner performing delegated medical acts. When application is made for more than the equivalent of three full‑time NPs, CNMs, or CNSs to practice with one physician, or when a NP, CNM, or CNS is performing delegated medical acts in a practice site greater than forty‑five miles from the physician, the Board of Nursing and the Board of Medical Examiners shall review the application to determine if adequate supervision exists.

(44) “Reinstatement” means an action of the board in a disciplinary matter that authorizes the resumption of practice upon any terms or conditions ordered or agreed to by the board.

(45) “Relinquish” means to permanently cancel or invalidate an authorization instead of disciplinary proceedings or final decision by the board. A person whose authorization to practice has been relinquished to the board is permanently ineligible for a license or other authorization of any kind from the board. Relinquishment is irrevocable, an admission of any or all of the allegations of misconduct, and reported and treated as a permanent revocation.

(46) “Respondent” means a person charged with responding in a disciplinary or other administrative action.

(47) “Revocation” means the permanent cancellation or withdrawal of an authorization issued by the board. A person whose authorization has been permanently revoked by the board is permanently ineligible for an authorization of any kind from the board.

(48) “Significant disciplinary action” means a public decision in a disciplinary matter that involves substantial issues of professional or ethical competence or qualification to practice. The board may consider any actions taken by the original board or conduct considered relevant to the applicant’s fitness for licensure to practice in this State.

(49) “State identification bureau” means an authorized governmental agency responsible for receiving and screening the results of criminal history records checks in this State or another state.

(50) “Supervision” means the process of critically observing, directing, and evaluating another person’s performance, unless otherwise provided by law.

(51) “Suspension” means the temporary withdrawal of authorization to practice for either a definite or indefinite period of time ordered by the board. The holder of a suspended authorization to practice may petition the board for reinstatement to practice upon compliance with all terms and conditions imposed by the board.

(52) “Telemedicine” means the practice of medicine using electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening practitioner.

(53) “Temporary license” means a current, time‑limited document that authorizes practice at the level for which one is seeking licensure.

(54) “Unprofessional conduct” means acts or behavior that fail to meet the minimally acceptable standard expected of similarly situated professionals including, but not limited to, conduct that may be harmful to the health, safety, and welfare of the public, conduct that may reflect negatively on one’s fitness to practice, or conduct that may violate any provision of the code of ethics adopted by the board or a specialty.

(55) “Voluntary surrender” means forgoing the authorization to practice by the subject of an initial or formal complaint pending further order of the board. It anticipates other formal action by the board and allows any suspension subsequently imposed to include this time.

(56) “Volunteer license” means authorization of a retired practitioner to provide medical services to others through an identified charitable organization without remuneration.

HISTORY: 2006 Act No. 385, Section 1; 2008 Act No. 411, Section 6; 2016 Act No. 210 (S.1035), Section 3, eff June 3, 2016.

Editor’s Note

On August 24, 2006, the Supreme Court of South Carolina issued the following order, 2006‑08‑24‑01, RE: Act No. 385 of 2006 — relating to defining the “practice of medicine”:

“Act No. 385 of 2006 — ratified 6/7/2006 and effective 6/9/2006 — substantially revises Chapter 47 of Title 40 of the South Carolina Code; the chapter dealing with ‘physicians, surgeons, and osteopaths.’ The Act contains the following language:

‘Practice of Medicine’ means:

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‘(h) testifying as a physician in an administrative, civil, or criminal proceeding in this State by expressing an expert medical opinion.’

“Section 40‑47‑20(36), Act No. 385, 2006 S.C. Acts \_\_\_. Furthermore, the Act provides significant detail regarding the information that the South Carolina Board of Medical Examiners shall require before issuing a ‘limited license’ to a physician licensed in good standing in another state who has been engaged to testify as an expert medical witness in an administrative or judicial proceeding in South Carolina. Section 40‑47‑35, Act No. 385, 2006 S.C. Acts \_\_\_.

“Traditionally, court rules allowed any witness who was qualified as an expert by knowledge, skill, experience, training, or education to offer expert testimony in a South Carolina court. Rule 702, SCRE. Furthermore, in a lawsuit alleging a cause of action for medical malpractice, the general rule is that expert testimony is required to show that the defendant failed to conform to the required standard of care; specifically, the reasonable and ordinary knowledge, skill, and diligence physicians in similar neighborhoods and surroundings ordinarily use under like circumstances. Green v. Lilliewood, 272 S.C. 186, 192, 249 S.E.2d 910, 913 (1978) (quoting Jarboe v. Harting, 397 S.W.2d 775, 778 (Ky. 1965)). Thus, although no South Carolina statute or court rule has ever embraced the higher scrutiny applied as a pre‑requisite for the admission of expert testimony enunciated in Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579 (1993), our rules have always charged the court with performing a ‘gate keeping’ function in limiting the presentation of expert testimony to situations where the testimony will assist the trier of fact in understanding evidence or determining a fact in issue.1

“After careful consideration, we believe that while the General Assembly certainly sought, through Act 385, to make needed revisions to the methods South Carolina courts utilize in the area of expert medical testimony, the effect of the revised statutes has the potential to substantially impair the orderly administration of justice. Specifically, Act 385 casts serious doubt on a physician’s ability to offer testimony regarding the treatment provided to a witness, party litigant, or criminal defendant if the physician, at the time of trial, resides outside of South Carolina. This categorical exclusion overlooks the fact that the physician may have treated the patient in the physician’s home jurisdiction, and also that the physician, although at one time licensed and providing treatment to the patient in South Carolina, has relocated out of this state. We believe requiring a treating physician to seek a South Carolina medical license before offering often necessary testimony strains Act 385 far beyond its intended scope.

“Additionally, Act 385 is ambiguous as to its relevance to pre‑trial practices and proceedings that are of fundamental importance to the judicial process. For example, Act 385’s applicability to witnesses used during discovery that might not be used at trial is unclear. Furthermore, although expert testimony is traditionally presented by a witness offering live testimony, lawyers often draw heavily from learned treatises authored by prominent national experts. It would do a great disservice to our system of justice if the doors of South Carolina courtrooms were closed to these scholarly works and the country’s leading medical scholars, who may have no intentions of ever visiting this jurisdiction, because our state law would deem them unqualified to offer expert testimony by virtue of their refusal to subject themselves to the disciplinary authority of the South Carolina Board of Medical Examiners.2

“The South Carolina Constitution vests this Court with the authority to make rules governing the administration of the unified South Carolina court system. S.C. Const. Art V, Section 4. In order to prevent a significant impairment to this Court’s duty to properly administer the judicial power of South Carolina, and pursuant to Article V, Section 4’s authority, we hereby temporarily delay judicial enforcement of Act 385 insofar as the Act requires a physician to obtain a license to practice medicine in South Carolina before offering expert medical testimony in a South Carolina administrative or court proceeding.3

“While we remain respectful of the General Assembly’s voice in matters of practice and procedure in South Carolina’s courts, this Court cannot allow the administration of justice to be substantially impaired. We are confident, however, that when the General Assembly provides further clarity on this matter, the changes that result will reflect careful consideration and deliberation; will consider and account for the scope of the court’s existing rules and the need for efficient and orderly court administration; and will be subjected to close scrutiny in the Judiciary Committees of both the South Carolina Senate and the House of Representatives.

“This order is effective immediately and shall remain in effect until further order of this Court.

“FOOTNOTES:

“1In Daubert, the United States Supreme Court interpreted Rule 702 of the Federal Rules of Evidence to require trial courts to ensure that all testimony offered as expert scientific, technical, or specialized testimony be both relevant and reliable, be grounded in scientific methods and procedures, and be supported by appropriate scientific validation. 509 U.S. at 589‑92. Furthermore, the court interpreted federal evidentiary rules to require ‘a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue.’ Id. at 592‑93. Although Rule 702, SCRE, contains identical language to the federal rule, we have expressly declined to adopt this interpretation in South Carolina. See State v. Council, 335 S.C. 1, 20, 515 S.E.2d 508, 518 (1999) (declining to adopt Daubert; interpreting the South Carolina Rules of Evidence to require the trial judge to determine that the evidence will assist the trier of fact, that the expert witness is qualified, and that the underlying science is reliable; and adopting the factors set forth in State v. Jones, 273 S.C. 723, 259 S.E.2d 120 (1979) for determining the reliability of the offered evidence).

“2We also note that although Title 40 of the Code has always contained civil and criminal penalties for violations of the title’s licensing requirements and for aiding and abetting one who violates those provisions, see S.C. Code Ann. Sections 40‑1‑210, 40‑47‑260 (2001), Act 385’s significantly broader definition of the ‘practice of medicine’ and licensing requirements now introduce the possibility of incurring these penalties in connection with conducting a trial in South Carolina.

“Furthermore, the Act defines the ‘practice of medicine’ to include ‘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.’ Section 40‑47‑20(36), Act No. 385, 2006 S.C. Acts \_\_\_. In an effort to ensure that unintended consequences do not overwhelm the noble motives of the legislation, these factors further necessitate our issuing this order.

“3Because we are not presently presented with a case or controversy questioning the constitutionality of Act 385, we reserve those serious questions for another day. At the present, we rely exclusively on our Constitutional authority to police the orderly administration of justice in the South Carolina courts.”

Prior Laws:1904 (24) 512; 1905 (24) 938; 1908 (25) 1083; Civ. C. ‘12 Section 1618; 1920 (31) 1004; Civ. C. ‘22 Section 2400; 1932 Code Section 5150; 1942 Code Section 5150; 1952 Code Section 56‑1354; 1962 Code Section 56‑1354; 1976 Code Section 40‑47‑40.

Effect of Amendment

2016 Act No. 210, Section 3, added (52), definition of telemedicine, and redesignated former (52) through (55) as (53) through (56).

**SECTION 40‑47‑25.** Rights and privileges of licensees.

Osteopathic physicians and surgeons licensed hereunder shall have the same rights and privileges as physicians and surgeons of other schools of medicine with respect to the treatment of cases, hospital privileges, and the holding of health offices or offices of public institutions. Physicians and surgeons licensed pursuant to this chapter must be licensed to practice medicine in all its branches regardless of whether the physician holds an M.D. or D.O. degree and has passed the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX—USA) examination sequence, or graduated from a college accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA), Commission on Osteopathic College Accreditation (COCA), or successfully completed post‑graduate training from the American Council for Graduate Medical Education (ACGME) approved or AOA‑approved programs, or obtained American Board of Medical Specialties (ABMS) or AOA board certification, or on the basis of his or her race, color, creed, religion, sex, or national origin.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑30.** Licensure requirement; excepted activities; physician licensed in another state.

(A) A person may not practice medicine in this State unless the person is twenty‑one years of age and has been authorized to do so pursuant to the provisions of this article. Nothing in this article may be construed to:

(1) prohibit service in cases of emergency or the domestic administration of family remedies;

(2) apply to those who practice the religious tenets of their church without pretending a knowledge of medicine if the laws, rules, and regulations relating to contagious diseases and sanitary matters are not violated;

(3) prohibit licensed pharmacists from selling, using, and dispensing drugs in their places of business;

(4) allow under any circumstances, physicians’ assistants or optometrists’ assistants to make a refraction for glasses or give a contact lens fitting;

(5) prohibit a licensed physician from delegating tasks to unlicensed personnel in the physician’s employ and on the premises if:

(a) the task is delegated directly to unlicensed personnel by the physician and not through another licensed practitioner;

(b) the task is of a routine nature involving neither the special skill of a licensed person nor significant risk to the patient if improperly done;

(c) the task is performed while the physician is present on the premises and in such close proximity as to be immediately available to the unlicensed person if needed;

(d) the task does not involve the verbal transmission of a physician’s order or prescription to a licensed person if the licensed person requires the order or prescription to be in writing; and

(e) the unlicensed person wears an appropriate badge denoting to a patient the person’s status. The unlicensed person shall wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the person’s first name at a minimum and staff position. The identification badge must be worn in a manner so that it is clearly visible to patients at all times;

(6) prohibit the practice of any legally qualified licensee of another state who is employed by the United States government or any department, bureau, division, or agency of the United States government, while in the discharge of official duties;

(7) prohibit students while engaged in training in a medical school approved by the board;

(8) prohibit practicing dentistry, nursing, optometry, podiatry, psychology, or another of the healing arts in accordance with state law;

(9) prohibit the practice of any legally qualified licensee of another state involved in the transport of patients to medical facilities or the lawful procurement of organs or other body parts for medical use.

(10) prohibit a physician from practicing in actual consultation with a physician licensed in this State concerning an opinion for the South Carolina physician’s consideration in managing the care or treatment of a patient in this State.

(B)(1) A physician licensed in another state, territory, or other jurisdiction of the United States or of any other nation or foreign jurisdiction is exempt from the requirements of licensure in this State, if the physician:

(a) holds an active license to practice in the other jurisdiction;

(b) engages in the active practice of medicine in the other jurisdiction; and

(c) is employed or designated as the team physician by an athletic team visiting the State for a specific sporting event or team training camp.

(2) A physician’s practice pursuant to this section is limited to the members, coaches, and staff of the team by which the physician is employed or designated. A physician practicing in this State pursuant to this section does not have practice privileges in any licensed health care facility and is not authorized to issue orders or prescriptions or to order testing at a medical facility in this State.

(C) Nothing in this chapter may be construed to authorize a physician to delegate the performance of radiological services in violation of Chapter 74 of Title 44.

HISTORY: 2006 Act No. 385, Section 1; 2008 Act No. 411, Sections 1, 2; 2016 Act No. 212 (S.1037), Section 1, eff June 3, 2016.

Editor’s Note

Prior Laws:1881 (17) 571; 1887 (19) 820; 1888 (20) 54; 1890 (20) 699; Civ. C. ‘02 Section 1112; 1904 (24) 512; 1905 (24) 938; 1908 (25) 1083; Civ. C. ‘12 Section 1618; 1920 (31) 1004; Civ. C. ‘22 Sections 2399, 2400; 1932 Code Sections 5149, 5150; 1942 Code Sections 5149, 5150; 1952 Code Section 56‑1355; 1962 Code Section 56‑1355; 1969 (56) 754; 1974 (58) 1948; 1982 Act No. 406; 1976 Code Section 40‑47‑60.

Effect of Amendment

2016 Act No. 212, Section 1, in (B)(1)(c), inserted “or team training camp”.

**SECTION 40‑47‑31.** Limited and temporary licenses.

(A) Limited licenses may be issued for postgraduate medical residency training or for employment with a state agency, as approved by the board. A limited license entitles the licensee to apply for individual controlled substance registration through the Department of Health and Environmental Control. Each limited license is valid for one year or part of one year. Renewal may be considered upon approval of the board. A special limited license also may be issued to a physician licensed in another state for up to fourteen days not more than four times a year in order to authorize practice under supervision for training involving direct patient care or to explore potential employment relationships.

(B) Applicants for a limited license for medical residency training who are graduates of an approved medical school located in the United States or Canada must complete and submit an application and the appropriate application fee. A completed application must include the following:

(1) a copy of a contract in which the applicant has been offered a position in a medical residency training program accredited by the American Council for Graduate Medical Education or American Osteopathic Association or a fellowship or a letter from the institution stating the applicant has been recommended for a medical residency training program or a fellowship. The recommendation letter must be addressed and mailed directly to the board office from the institution;

(2) a certification of medical education form approved by the board to be completed by the dean, the president, or the registrar of the applicant’s medical school or as approved by the board;

(3) a supervising physician form approved by the board to be completed by the chairman or residency director of the training program;

(4) letters of recommendation from licensed physicians recommending the applicant for a limited license in this State; and

(5) verification of licensure in other states, if applicable.

(C) An applicant for a limited license for medical residency training who is a graduate of a medical school located outside the United States or Canada may be considered on an individual basis. Such applicants shall complete and submit an application and the appropriate application fee. In addition to all other requirements, a completed application must include a copy of a current or permanent Educational Commission for Foreign Medical Graduates (ECFMG) certificate or documentation of successful completion of a Fifth Pathway program, or both. The board may waive this requirement if the applicant has a full‑time academic faculty appointment at the rank of assistant professor or greater in a medical school in this State accredited by the American Council for Graduate Medical Education or the American Osteopathic Association. This requirement also may be waived if the applicant:

(1) has been licensed for five years or more without significant disciplinary action; and

(2) holds current certification by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association or another organization approved by the board.

(D) A physician in a medical residency training program in this State may apply for a permanent license at least ninety days before his or her limited license expires. No part of a limited license application may be applied to an application for a permanent license. Each application must be filed separately.

(E) A new application for a limited license for employment with a state agency may not be authorized after January 1, 2001. A current holder of a limited license for employment with a state agency may renew his or her limited license if no change of agency has occurred. A change in agency may be approved upon presentation to the board of a copy of a contract in which the limited license holder has been offered a position within the South Carolina Department of Corrections, the South Carolina Department of Health and Environmental Control, the South Carolina Department of Mental Health, or the South Carolina Department of Disabilities and Special Needs.

(F) A special limited license may be issued to a physician licensed in another state to authorize practice under supervision for training involving direct patient care or to explore potential employment relationships. The applicant must submit the following items:

(1) a completed application and payment of applicable fees; and

(2) a documentation from the supervising physician relating the purpose and dates requested.

(G) An emergency limited license may be issued to a physician actively licensed in another state who is in good standing in accordance with Section 40‑47‑160(B) and whose place of established practice has been the subject of an emergency disaster declaration by an appropriate federal or state authority. An emergency limited license is valid for one year and may be renewed upon approval of the board. This license must be limited to practice in this State while associated with a licensed physician in this State who holds an unrestricted, permanent license or while employed by a licensed healthcare facility in this State. The applicant must submit the following items:

(1) a completed application and payment of applicable fees; and

(2) such documentation as may be acceptable to the board under the circumstances to demonstrate eligibility for the limited license, including documentation of an existing license in good standing authorizing professional practice in the state which is subject to the emergency disaster declaration.

(H) A temporary license may be issued to an applicant who has met all requirements for the issuance of a permanent license, except such final verifications as may be required. A temporary license is valid for three months or more, if approved by the board. Renewal may be considered upon approval of the board.

(I) The board may not issue a limited or temporary license to a licensed physician of another state of the United States:

(1) whose license is currently revoked, suspended, restricted in any way, or on probationary status in that state; or

(2) who currently has disciplinary action pending in any state.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

Prior Laws:1905 (24) 939; Civ. C. ‘12 Section 1621; 1920 (31) 1004; Civ. C. ‘22 Section 2403; 1932 Code Section 5153; 1942 Code Section 5153; 1952 Code Section 56‑1356; 1962 Code Section 56‑1356; 1970 (56) 2371; 1976 Code Section 40‑47‑80.

**SECTION 40‑47‑32.** Permanent licenses; requirements; examinations; post‑graduate medical residency training requirements; fee.

(A) To obtain a permanent license to practice medicine in this State an applicant shall comply with the requirements of this section.

(B)(1) An applicant shall document to the satisfaction of the board graduation from a:

(a) medical school located in the United States or Canada that is accredited by the Liaison Committee on Medical Education or other accrediting body approved by the board;

(b) school of osteopathic medicine located in the United States or Canada accredited by the Commission on Osteopathic College Accreditation or other accrediting body approved by the board;

(c) medical school located outside the United States or Canada.

(2) An applicant who graduated from a medical school located outside of the United States shall:

(a)(i) possess a permanent Standard Certificate from the Education Commission on Foreign Medical Graduates (ECFMG); and

(ii) document a minimum of three years of progressive postgraduate medical residency training in the United States approved by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons, except that if an applicant has been actively licensed in another state for the preceding five years or more without significant disciplinary action, the applicant need only document one year of postgraduate residency training approved by the board; or

(b)(i) document successful completion of a Fifth Pathway program; and

(ii) complete a minimum of three years progressive postgraduate medical residency training in the United States approved by the ACGME or AOA or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons or be board eligible or board certified by a specialty board recognized by the American Board of Medical Specialties (ABMS), the AOA, or another organization approved by the board;

(c) notwithstanding the provisions of this subsection, the board may waive the ECFMG or Fifth Pathway requirement if the applicant is to have a full‑time academic faculty appointment at the rank of assistant professor or greater at a medical school in this State.

(C) An applicant shall document to the satisfaction of the board successful completion of:

(1) all parts of the National Board of Medical Examiners Examination in approved sequence;

(2) all parts of the National Board of Osteopathic Medical Examiners Examination in approved sequence;

(3) the Federation Licensing Exam (FLEX) based on standards established by the board;

(4) the United States Medical Licensing Examination (USMLE) based on standards established by the board;

(5) the Medical Council of Canada Qualifying Examination (MCCQE) in approved sequence;

(6) the Comprehensive Osteopathic Medical Licensing Examination (COMLEX—USA);

(7) a written state examination of another state medical, osteopathic, or composite board prior to 1976, and current certification by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or another organization approved by the board; or

(8) combinations of the FLEX, National Board of Medical Examiners, and USMLE acceptable to the Composite Committee of the USMLE and approved by the board. These combinations may be accepted only if taken before 1999.

(D) In addition to meeting all other licensure requirements, an applicant shall pass the Special Purpose Examination (SPEX) or the Composite Osteopathic Variable‑Purpose Examination (COMVEX), unless the applicant can document within ten years of the date of filing a completed application to the board one of the following:

(1) National Board of Medical Examiners examination;

(2) National Board of Osteopathic Medical Examiners examination;

(3) FLEX;

(4) USMLE;

(5) MCCQE;

(6) SPEX;

(7) COMVEX;

(8) COMLEX—USA;

(9) ECFMG;

(10) certification, recertification, or a certificate of added qualification examination by a specialty board recognized by either the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or another organization approved by the board; or

(11) one hundred fifty hours of Category I continuing medical education in the three years preceding the date of the application by an applicant who is currently certified by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or other organization approved by the board, which certification is not time limited and does not require recertification by examination. Such Category I continuing medical education must be approved by the American Medical Association or American Osteopathic Association, or other national organization approved by the board, as appropriate. Seventy‑five percent of these hours must be related to the applicant’s area of specialty. This is the only exception to the ten year requirement of this subsection that does not require an examination or reexamination.

(E) The additional examination required pursuant to subsection (D) must be waived if the applicant is to practice in a position within the South Carolina Department of Corrections, South Carolina Department of Health and Environmental Control, South Carolina Department of Mental Health, or the South Carolina Department of Disabilities and Special Needs. A license issued pursuant to this waiver is immediately invalid if the individual leaves that position or acts outside the scope of employment within the department. A change in agency may be approved upon presentation to the board of a copy of a contract in which the individual has been offered a position within the South Carolina Department of Corrections, the South Carolina Department of Health and Environmental Control, the South Carolina Department of Mental Health, or the South Carolina Department of Disabilities and Special Needs.

(F) In addition to the following standards, the board shall establish minimum standards of performance to be attained on examinations for an applicant to qualify for licensure:

(1) For FLEX examinations taken before June 1, 1985, the following standards apply:

(a) An applicant for permanent licensure shall obtain, in one sitting, a FLEX weighted average score of at least seventy‑five on the examination.

(b) FLEX examinations taken before June 1, 1985, were administered in three days and the days were referred to as Day 1, Day 2, and Day 3. In case of failure, the results of the first three takings of each day must be considered by the board, and the board may consider the results from a fourth taking of any day; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant’s additional medical education or training, the applicant’s score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of Day 1, Day 2, or Day 3, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

(2) For FLEX examinations taken after June 1, 1985, the following standards apply:

(a) An applicant for permanent licensure shall obtain a score of seventy‑ five or more on both Component I and Component II. An applicant shall pass both components within five years of the first taking of any component of this examination.

(b) FLEX examinations taken after June 1, 1985, were administered as Component I and Component II. In case of failure, the results of the first three takings of each component must be considered by the board. The board may consider the results from a fourth taking of any component; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant’s additional medical education or training, the applicant’s score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of Component I or Component II, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

(3) For the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination, or the Medical Council of Canada Qualifying Examination, the applicant shall pass all steps within ten years of passing the first taken step. The results of the first three takings of each step examination must be considered by the board. The board may consider the results from a fourth taking of any step; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant’s additional medical education or training, the applicant’s score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of any step, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

(G) With respect to postgraduate medical residency training requirements, the following standards apply:

(1) Graduates of approved medical or osteopathic schools located in the United States or Canada shall document the successful completion of a minimum of one year of postgraduate medical residency training approved by the board.

(2) Graduates of medical schools located outside the United States or Canada shall document a minimum of three years of progressive postgraduate medical residency training approved by the board, except that these graduates who have completed at least two and one‑half years of progressive postgraduate medical residency training in the program in which they are currently enrolled may be issued a license upon certification from the program of their good standing and expected satisfactory completion. These graduates who have been actively licensed in another state for the preceding five years or more without significant disciplinary action need only document one year of postgraduate residency training approved by the board. A foreign graduate may satisfy the three year postgraduate training requirement with at least one year of approved training in combination with certification by a specialty board recognized by the ABMS, AOA, or another national organization approved by the board.

(3) The board may accept a full‑time academic appointment at the rank of assistant professor or greater in a medical or osteopathic school in the United States as a substitute for and instead of postgraduate medical residency training. Each year of this academic appointment may be credited as one year of postgraduate medical residency training for purposes of the board’s postgraduate training requirements.

(4) For purposes of satisfying postgraduate medical residency training requirements, the board may accept postgraduate training in the United States approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons.

(H) An applicant may be denied licensure if the individual has committed acts or omissions that are grounds for disciplinary action as provided for in Section 40‑47‑110. The board or department immediately may cancel an authorization that was issued based on false, fraudulent, or misleading information provided by an applicant.

(I) The board may grant or refuse licensure to licentiates of the National Board of Medical Examiners, the Medical Council of Canada, or of the National Board of Osteopathic Medical Examiners without further examination and may make and establish all necessary rules and regulations for the endorsement of licensure issued by other state boards having substantially equivalent requirements.

(J) An applicant for a permanent license shall document compliance with applicable continued competency requirements.

(K) An applicant shall file a completed application, with required supporting documentation, on forms provided by the department. Primary source verification of an applicant’s identity, medical education, postgraduate training, examination history, disciplinary history, and other core information required for licensure in this State must be provided through an independent credentials verification organization approved by the board.

(L) A nonrefundable permanent license application fee must be submitted with the application. Applications will not be processed without the required fee.

(M) The board must not issue a permanent license to a licensed physician of another state of the United States:

(1) whose license is currently revoked, suspended, restricted in any way, or on probationary status in that state; or

(2) who currently has disciplinary action pending in any state.

HISTORY: 2006 Act No. 385, Section 1; 2008 Act No. 411, Sections 3, 4, and 5.

**SECTION 40‑47‑33.** Academic license; qualifications; responsibility of dean for compliance with practice limitations.

(A) The issuance of an academic license is initiated by a written request from the dean of the medical school outlining the candidate’s credentials, proposed role at the academic institution, and the reasons for requesting an exception to the usual course of permanent licensure. The candidate shall meet the following requirements:

(1) The individual must have the rank of assistant professor or higher.

(2) The individual must have established academic credentials and a compelling reason to be invited by the dean.

(3) The academic license may be used only in the educational setting or in a training program associated with the medical school.

(4) Use of the academic license is limited to the designated practice site only. It is not for independent practice or “moonlighting” situations.

(B) In that an academic license is issued at the dean’s request for his accommodation, the dean is professionally responsible under Section 40‑47‑110 for the academic licensee’s compliance with the limitations of practice under an academic license.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑34.** Special volunteer licenses; waiver of fees; restrictions; qualifications.

(A) The board shall waive all application fees, examination fees, and annual reregistration fees for an applicant who applies for a special volunteer license and who otherwise meets permanent licensure requirements if the applicant documents, to the satisfaction of the board, that practice is to be exclusively and totally devoted to providing medical care to the needy and indigent in this State. To be eligible for the waiver of these fees, an applicant shall acknowledge that there is no expectation of payment or compensation for any medical services rendered, or compensation or payment to the applicant, either direct or indirect, monetary or in‑kind, for the provision of medical services. A special volunteer license entitles the licensee to apply for individual controlled substance registration through the Department of Health and Environmental Control.

(B) A special volunteer license may be issued to a qualified applicant upon approval by the board. Practice must be limited to each specific site and practice setting approved by the board. There must be no licensure or other fees associated with a special volunteer license.

(C) Requirements for a special volunteer license are as follows:

(1) satisfactory completion of a special volunteer license application, including documentation of medical or osteopathic school graduation and practice history;

(2) documentation of specific proposed practice location;

(3) documentation that the applicant previously has been issued an unrestricted license to practice medicine in South Carolina or in another state of the United States or Canada and that the applicant has never been the subject of any significant disciplinary action in any jurisdiction;

(4) documentation that the applicant shall only practice under the supervision of a supervising physician approved by the board. In order to ensure that public health, safety, and welfare are protected, the board shall review the proposed supervisory relationship to ensure that the physician supervisor is competent to supervise the special volunteer licensee. Factors the board shall consider include, but are not limited to, the training and practice experience of the supervising physician, the current nature and extent of the supervising physician’s practice, the existence of any recent demonstration of the supervising physician’s clinical competency, and the number of special volunteer licensees the physician proposes to supervise;

(5) documentation of the name of the supervising physician and that the physician has agreed to accept this supervisory responsibility. Supervising physicians shall possess an active, unrestricted permanent license to practice medicine in this State. An approved supervising physician physically must be on the premises whenever a special volunteer licensee is practicing medicine;

(6) documentation and acknowledgement that the applicant may not receive payment or compensation, either direct or indirect, or have any expectation of payment or compensation for medical services rendered, and the supervising physician may not receive compensation or payment as the result of the special volunteer licensee’s provision of medical services.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑35.** Licensure as expert medical witness; waiver of fee.

(A) The board may issue a license to a physician licensed in good standing in another state, who has been engaged to testify as an expert medical witness in an administrative, civil, or criminal proceeding in this State. The license only shall authorize practice in this State as an expert medical witness in a particular proceeding in this State. This license must be valid for the duration of the particular proceeding for which it is issued. This license must authorize only practice in this State that is related directly to the particular proceeding for which it is issued. A separate license must be obtained for each proceeding in which the applicant is engaged to testify as an expert medical witness in this State. The applicant shall submit the following items:

(1) a completed application and payment of applicable fees; and

(2) satisfactory documentation of the applicant’s engagement as an expert witness in a particular proceeding in this State.

(B) The board may waive any part or all of a fee for this license for a physician to testify as an expert witness on behalf of a state, county, or municipal agency or office.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑36.** Criminal history background checks; costs; confidentiality of information obtained.

(A) In addition to other requirements established by law and for the purpose of determining an applicant’s eligibility for an authorization to practice, the department may require a criminal history background check of each applicant for an authorization to practice pursuant to this chapter. Each applicant may be required to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division or the State Identification Bureau of another state and the Federal Bureau of Investigation, if no disqualifying record is identified at the state level. Costs of conducting a criminal history background check must be borne by the applicant. The department shall keep information received pursuant to this section confidential, except that information relied upon in denying an authorization to practice may be disclosed as may be necessary to support the administrative action.

(B) In an investigation or disciplinary proceeding concerning a licensee, the department may require a criminal history background check of a licensee. A licensee may be required to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division or the State Identification Bureau of another state and the Federal Bureau of Investigation, if no pertinent information is identified at the state level. Costs of conducting a criminal history background check must be borne by the department and may be recovered as administrative costs associated with an investigation or hearing pursuant to this chapter, unless ordered by the board as a cost in a disciplinary proceeding. The department shall keep information received pursuant to this section confidential, except that information relied upon in an administrative action may be disclosed as may be necessary to support the administrative action.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑37.** Practice of telemedicine, requirements.

(A) A licensee who establishes a physician‑patient relationship solely via telemedicine as defined in Section 40‑47‑20(52) shall adhere to the same standard of care as a licensee employing more traditional in‑person medical care and be evaluated according to the standard of care applicable to the licensee’s area of specialty. A licensee shall not establish a physician‑patient relationship by telemedicine pursuant to Section 40‑47‑113(B) for the purpose of prescribing medication when an in‑person physical examination is necessary for diagnosis. The failure to conform to the appropriate standard of care is considered unprofessional conduct under Section 40‑47‑110(B)(9).

(B) A licensee who establishes a physician‑patient relationship solely via telemedicine as defined in Section 40‑47‑20(52) shall generate and maintain medical records for each patient using such telemedicine services in compliance with any applicable state and federal laws, rules, and regulations, including this chapter, the Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (HITECH). Such records shall be accessible to other practitioners and to the patient in a timely fashion when lawfully requested to do so by the patient or by a lawfully designated representative of the patient.

(C) In addition to those requirements set forth in subsections (A) and (B), a licensee who establishes a physician‑patient relationship solely via telemedicine as defined in Section 40‑47‑20(52) shall:

(1) adhere to current standards for practice improvement and monitoring of outcomes and provide reports containing such information upon request of the board;

(2) provide an appropriate evaluation prior to diagnosing and/or treating the patient, which need not be done in‑person if the licensee employs technology sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care; provided, that evaluations in which a licensee is at a distance from the patient, but a practitioner is able to provide various physical findings the licensee needs to complete an adequate assessment, is permitted; further, provided, that a simple questionnaire without an appropriate evaluation is prohibited;

(3) verify the identity and location of the patient and be prepared to inform the patient of the licensee’s name, location, and professional credentials;

(4) establish a diagnosis through the use of accepted medical practices, which may include patient history, mental status evaluation, physical examination, and appropriate diagnostic and laboratory testing in conformity with the applicable standard of care;

(5) ensure the availability of appropriate follow‑up care and maintain a complete medical record that is available to the patient and other treating health care practitioners, to be distributed to other treating health care practitioners only with patient consent and in accordance with applicable law and regulation;

(6) prescribe within a practice setting fully in compliance with this section and during an encounter in which threshold information necessary to make an accurate diagnosis has been obtained in a medical history interview conducted by the prescribing licensee; provided, however, that Schedule II and Schedule III prescriptions are not permitted except for those Schedule II and Schedule III medications specifically authorized by the board, which may include, but not be limited to, Schedule II‑nonnarcotic and Schedule III‑nonnarcotic medications; further, provided, that licensees prescribing controlled substances by means of telemedicine must comply with all relevant federal and state laws including, but not limited to, participation in the South Carolina Prescription Monitoring Program set forth in Article 15, Chapter 53, Title 44; further, provided, that prescribing of lifestyle medications including, but not limited to, erectile dysfunction drugs is not permitted unless approved by the board; further, provided, that prescribing abortion‑inducing drugs is not permitted; as used in this article “abortion‑inducing drug” means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child. This includes off‑label use of drugs known to have abortion‑inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol (Cytotec), and methotrexate. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications including, but not limited to, chemotherapeutic agents or diagnostic drugs. Use of such drugs to induce abortion is also known as “medical”, “drug‑induced”, and/or “chemical abortion”;

(7) maintain a complete record of the patient’s care according to prevailing medical record standards that reflects an appropriate evaluation of the patient’s presenting symptoms; provided that relevant components of the telemedicine interaction be documented as with any other encounter;

(8) maintain the patient’s records’ confidentiality and disclose the records to the patient consistent with state and federal law; provided, that licensees practicing telemedicine shall be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as licensees practicing via traditional means; further, provided, that if a patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider’s medical record and the telemedicine provider’s record constitute one complete medical record;

(9) be licensed to practice medicine in South Carolina; provided, however, a licensee need not reside in South Carolina so long as he or she has a valid, current South Carolina medical license; further, provided, that a licensee residing in South Carolina who intends to practice medicine via telemedicine to treat or diagnose patients outside of South Carolina shall comply with other state licensing boards; and

(10) discuss with the patient the value of having a primary care medical home and, if the patient requests, provide assistance in identifying available options for a primary care medical home.

(D) A licensee, practitioner, or any other person involved in a telemedicine encounter must be trained in the use of the telemedicine equipment and competent in its operation.

(E) Notwithstanding any of the provisions of this section, the board shall retain all authority with respect to telemedicine practice as granted in Section 40‑47‑10(I) of this chapter.

HISTORY: 2016 Act No. 210 (S.1035), Section 2, eff June 3, 2016.

**SECTION 40‑47‑40.** Continuing professional education.

The continued professional competency of a physician holding a permanent license must be demonstrated in the following manner:

(1) For renewal of a permanent license initially issued during a biennial renewal period, compliance with all educational, examination, and other requirements for the issuance of a permanent license is sufficient for the first renewal period following initial licensure.

(2) For renewal of an active permanent license biennially, documented evidence of at least one of following options during the renewal period is required:

(a) forty hours of Category I continuing medical education sponsored by the American Medical Association, American Osteopathic Association, or another organization approved by the board as having acceptable standards for courses it sponsors, at least thirty hours of which must be related directly to the licensee’s practice area, and at least two (2) hours of which may be related to approved procedures of prescribing and monitoring controlled substances listed in Schedules II, III, and IV of the schedules provided for in Sections 44‑53‑210, 44‑53‑230, 44‑53‑250, and 44‑53‑270, and must be received from a statewide organization recognized by the Accreditation Council for Continuing Medical Education to recognize and accredit organizations in South Carolina offering continuing medical education or from a statewide organization approved to provide continuing medical education by its national organization which is accredited by the Accreditation Council for Continuing Medical Education. Each renewal form submitted pursuant to Section 40‑47‑41 must include a certificate of participation with the prescribing and monitoring education requirement issued by the organization from which the education was received;

(b) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification;

(c) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association;

(d) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination; or

(e) successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians.

(3) For reinstatement or reactivation of a permanent license from lapsed or inactive status of less than four years, documented evidence of at least one of the following options within the preceding two years is required:

(a) forty hours of Category I continuing medical education sponsored by the American Medical Association, American Osteopathic Association, or another organization approved by the board as having acceptable standards for courses it sponsors, at least thirty hours of which must be directly related to the licensee’s practice area;

(b) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification;

(c) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association;

(d) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination; or

(e) successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians.

(4) For reinstatement or reactivation of a permanent license from lapsed or inactive status of four years or more, documented evidence of at least one of the following options within the preceding two years is required:

(a) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification;

(b) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association;

(c) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination; or

(d) successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians.

(5) For reinstatement or reactivation of a lapsed or an inactive status of a permanent license of a licensee who has been in active practice in another state, compliance with any of the requirements of this section within the preceding two years is sufficient.

HISTORY: 2006 Act No. 385, Section 1; 2014 Act No. 244 (S.840), Section 5, eff June 6, 2014.

Effect of Amendment

2014 Act No. 244, Section 5, rewrote subsection (2)(A), adding text following “at least thirty hours of which must be related directly to the licensee’s practice area”.

**SECTION 40‑47‑41.** License renewal; notification of change of address or adverse disciplinary action in another jurisdiction.

(A) A license issued pursuant to this chapter may be renewed biennially or as otherwise provided by the board and department. A person who has not demonstrated continuing medical competence, as required by this chapter, is not eligible for issuance or renewal of an active license.

(B) A licensee shall complete the renewal form and submit the form to the board with the renewal fee. Upon receipt of the application and the fee, the department shall verify the accuracy of the application and renew the license for the applicable period. If a licensee fails to timely renew the license, the license is deemed lapsed at the close of the renewal period, and the licensee may not practice in this State until the licensee is reinstated to practice. The board may reinstate the licensee on payment of a reinstatement fee, the current renewal fee, and demonstration of continued competency satisfactory to the board. The board may deny reinstatement or take other action based on evidence of misconduct.

(C) A licensee shall notify the board in writing within fifteen business days of any change of residential address, office address, or office telephone number.

(D) A licensee shall notify the board within thirty days of any adverse disciplinary action by another United States or foreign licensing jurisdiction, a peer review group, a health care institution, a professional or medical society or association, a governmental agency, a law enforcement agency, including arrest, or a court, including indictment. Confidential information received from a licensee or other sources must continue to be maintained as confidential, except to the extent necessary for the proper disposition of the matter. Notification is not required in the case of:

(1) a nondisciplinary resignation by the licensee from a health care facility; however, a resignation occurring after an incident or occurrence which could result in the revocation or suspension of or other limitation upon the licensee’s privileges must be reported;

(2) a minor disciplinary action regarding the licensee’s privileges in a health care facility when the action taken does not involve the revocation or suspension of or other limitation upon the licensee’s privileges to practice there;

(3) a disciplinary action resulting from the licensee’s failure to meet recordkeeping standards in a health care institution;

(4) a disciplinary action resulting from the licensee’s failure to attend meetings of a health care institution; or

(5) other disciplinary actions as defined by the board in regulation.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑42.** Reactivation of inactive license.

A person with an inactive license to practice medicine in this State who wishes to resume active practice shall submit an application for reactivation including:

(1) a completed application form approved by the board;

(2) the applicable reactivation fee;

(3) documented evidence of compliance with applicable continued competency requirements;

(4) written verification of licensure and disciplinary history in all states in which a license has ever been issued; and

(5) a practice history, including any malpractice suits and judgments.

HISTORY: 2006 Act No. 385, Section 1.

**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.

**SECTION 40‑47‑44.** Application for reinstatement of license.

In addition to compliance with all of the terms and conditions for reinstatement of a licensee required in a final order of the board, the licensee shall provide documented evidence of compliance with all other requirements for reactivation or renewal of authorization to practice before authorization may be issued. It is the licensee’s responsibility to present clear and convincing evidence of rehabilitation that is satisfactory to the board. The board may require the licensee to personally appear in support of a petition for reinstatement or it may proceed upon information filed in the disciplinary matter or thereafter.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑45.** Appeal; presumption of service of notice of board action; review of motions for continuance and other interlocutory relief.

A final action of the board relating to the granting, refusal, or cancellation of a license is subject to review by the Administrative Law Court as provided pursuant to Article 5 of Chapter 23 of Title 1 on the record of the board, as in certiorari, upon petition of the applicant or licensee within thirty days from receipt of official notice from the board of the action of which review is sought. Service of this notice conclusively must be presumed ten days after mailing by registered or certified mail to the applicant or licensee of the notice at the person’s last known address. Motions for continuance and for other interlocutory relief are not subject to review by the Administrative Law Court until a final decision has been issued by the board.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑50.** Administrative support; fees to cover costs of operation of board; maintenance of records.

(A) The Department of Labor, Licensing and Regulation shall provide all administrative, fiscal, investigative, inspectional, clerical, secretarial, and license renewal operations and activities of the board in accordance with Section 40‑1‑50.

(B) Initial fees must be established by the board in statute or regulation and must serve as the basis for necessary adjustments in accordance with Section 40‑1‑50 to ensure that they are sufficient, but not excessive, to cover expenses, including the total of the direct and indirect costs to the State for the operations of the board.

(C) The administrator shall maintain a record of each formal complaint and of all final decisions on complaints, which must be retained permanently as part of the records of the board.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑70.** Code of ethics.

A practitioner shall conduct himself or herself in accordance with the applicable codes of ethics adopted by the board in regulation.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑80.** Investigation of complaints.

The department shall investigate complaints and violations as provided in Section 40‑1‑80.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑90.** Administering oaths.

In addition to the powers and duties enumerated in Section 40‑1‑90, the presiding officer of the board may administer oaths when taking testimony upon any and all matters pertaining to the business or duties of the board.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

Prior Laws:1908 (25) 1083; Civ. C. ‘12 Section 1622; 1920 (31) 1004; Civ. C. ‘22 Section 2404; 1932 Code Section 5154; 1942 Code Section 5154; 1952 Code Section 56‑1369; 1962 Code Section 56‑1369; 1970 (56) 2371; 1976 Act No. 614, Section 3; 1993 Act No. 181, Section 922; 1976 Code Section 40‑47‑210.

**SECTION 40‑47‑100.** Restraining orders.

Restraining orders and cease and desist orders may be issued in accordance with Section 40‑1‑100.

HISTORY: 1962 Code Section 56‑1357.1; 1956 (49) 1624; 1963 (53) 509; 1970 (56) 2371; 2006 Act No. 385, Section 1.

**SECTION 40‑47‑110.** Misconduct constituting grounds for disciplinary action; temporary suspensions; review of final actions; conduct subverting security or integrity of medical licensing examination process.

(A) In addition to the grounds provided in Section 40‑1‑110, upon finding misconduct that constitutes one or more of the grounds for disciplinary action the board may cancel, fine, suspend, revoke, issue a public reprimand or a private reprimand, or restrict, including probation or other reasonable action such as requiring additional education or training or limitation on practice, the authorization to practice of a person who has engaged in misconduct.

(B) “Misconduct” that constitutes grounds for disciplinary action is a showing to the board by the preponderance of evidence that a licensee has:

(1) used a false, fraudulent, or forged statement or document or practiced a fraudulent, deceitful, or dishonest act in connection with a licensing requirement;

(2) been convicted of, has pled guilty to, or has pled nolo contendere to a felony or other crime involving moral turpitude or drugs. For purposes of this item, “drugs” includes a substance whose possession, use, or distribution is governed by Article 3, Chapter 53 of Title 44, Narcotics and Controlled Substances, or which is listed in the current edition of the Physician’s Desk Reference;

(3) violated a federal, state, or local law involving alcohol or drugs or committed an act involving a crime of moral turpitude. The board may receive evidence to reach an independent conclusion as to the commission of the violation; however, the determination may be used only in making the administrative decision;

(4) engaged in the habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability;

(5) attempted to practice when judgment or physical ability is impaired by alcohol, drugs, or other substances;

(6) been convicted of or sanctioned for illegal or unauthorized practice;

(7) knowingly performed an act that in any way assists an unlicensed person to practice;

(8) sustained a physical or mental impairment that renders further practice by the licensee dangerous to the public or that may interfere with the licensee’s ability to competently and safely perform the essential functions of practice;

(9) engaged in dishonorable, unethical, or unprofessional conduct that is likely either to deceive, defraud, or harm the public;

(10) used a false or fraudulent statement in a document connected with the licensee’s practice;

(11) obtained fees or assisted in obtaining fees under dishonorable, false, or fraudulent circumstances;

(12) intentionally violated or attempted to violate, directly or indirectly, or is assisting in or abetting the violation of or conspiring to violate the medical practice laws;

(13) violated the code of medical ethics adopted by the board or has been found by the board to lack the ethical or professional competence to practice;

(14) violated a provision of this chapter or a regulation or order of the board;

(15) failed to cooperate with an investigation or other proceeding of the board;

(16) failed to comply with an order, subpoena, or directive of the board or department;

(17) failed to prepare or maintain an adequate patient record of care provided;

(18) engaged in disruptive behavior or interaction, or both, with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient. This behavior may include, but is not limited to, inappropriate sexual behavior;

(19) engaged in behavior that exploits the physician‑patient relationship in a sexual way. This behavior is nondiagnostic and nontherapeutic, may be written, verbal, or physical and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. This behavior includes sexual contact with patient surrogates or key third parties;

(20) failed to appear before the board after receiving a formal notice to appear;

(21) signed a blank prescription form;

(22) failed to report to the board any adverse disciplinary action by another United States or foreign licensing jurisdiction, a peer review body, a health care institution, by any professional or medical society or association, a board‑approved credentialing organization, a governmental agency, a law enforcement agency, including arrest, or a court, including indictment, for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action as provided for in this section;

(23) failed to provide pertinent and necessary medical records to another physician or patient in a timely fashion when lawfully requested to do so by a patient or by a lawfully designated representative of a patient;

(24) improperly managed medical records, including failure to maintain timely, legible, accurate, and complete medical records; or

(25) provided false, deceptive, or misleading testimony as an expert witness in an administrative, civil, or criminal proceeding in this State.

(C) In addition to all other remedies and actions incorporated in this chapter, a licensee who is adjudged mentally incompetent by a court of competent jurisdiction automatically must be suspended by the board until the licensee is adjudged by a court of competent jurisdiction, or in another manner provided by law, as being restored to mental competency. The automatic suspension of a license pursuant to this section is public information under the Freedom of Information Act.

(D) A decision by the board to revoke, suspend, or restrict a license or to limit or discipline a licensee must be by majority vote of the board members serving, except that the board may delegate to the chairman or vice chairman of the board the authority to issue orders to temporarily suspend licenses or to seek from the Administrative Law Court an order temporarily suspending or restricting a license pending final decision by the board, as follows:

(1) when the chairman or vice chairman of the board determines that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in an order, a temporary suspension order may be issued without a prior hearing being afforded to the licensee, in which event the licensee may request by the close of the next business day after receipt of the order a review by the administrative hearing officer. The fact of suspension or restriction of a license, and the fact of any subsequent related action, is public information under the Freedom of Information Act after issuance of an order by the chairman or vice chairman, unless a review by the administrative hearing officer has been timely requested in writing. Filing a written request for a review by the administrative hearing officer does not stay the temporary suspension and no stay may be issued; however, the fact of the issuance of the temporary suspension order must not be made public until the time for requesting a review has passed or the administrative hearing officer issues an order after a review hearing. Upon proper written request, a review hearing must be held by the administrative hearing officer within three business days of the filing of the request for review, unless otherwise agreed by the parties. If the issuance of the temporary suspension order is not sustained by the administrative hearing officer, the matter must remain confidential and must not be made public, except to the extent the board considers it relevant to the final decision of the board; or

(2) the Department of Labor, Licensing and Regulation, acting through the Office of General Counsel or its designee, at the direction of the chairman or vice chairman of the board, may petition the Administrative Law Court for an order temporarily suspending or restricting a license pending final decision by the board. A hearing must be held by the Administrative Law Court within three business days of the filing of the petition, unless otherwise agreed by the parties. If an order temporarily suspending or restricting a license is not issued by the administrative law judge, the matter must remain confidential and must not be made public, except to the extent the board considers it relevant to the final decision of the board. The fact of suspension or restriction of a license, and the fact of any subsequent related action, is public information under the Freedom of Information Act after issuance of an order by the Administrative Law Court.

(E) Motions for continuance and for other interlocutory relief are not subject to review by the Administrative Law Court until a final decision has been issued by the board. A licensee against whom disciplinary action is taken in a final decision pursuant to this article has the right to review by the Administrative Law Court as provided in Section 40‑1‑160. If the board has revoked, suspended, or restricted a license in any manner for six months or more, including probation conditions, an appeal taken to the Administrative Law Court as provided in Section 40‑1‑160 has precedence on the court’s calendar, is considered an emergency appeal, and should be heard not later than thirty days from the date the petition is filed. The review is limited to the record established by the board hearing. No stay or supersedeas may be granted by the administrative law judge or a reviewing court pending appeal from a final decision by the board to revoke, suspend, or restrict a license for six months or more.

(F)(1) If a person is found by the board to have engaged in conduct that subverts or attempts to subvert the security or integrity of the licensing examination process, the board may have the scores on the licensing examination withheld or declared invalid. The individual may be disqualified from practice or be subjected to the imposition of any other appropriate sanction provided by Section 40‑47‑120.

(2) Conduct that subverts or attempts to subvert the security or integrity of the medical licensing examination process includes, but is not limited to, conduct that violates the:

(a) security of examination materials including, but not limited to, the improper reproduction or reconstruction of any portion of the licensing examination; aiding in the improper reproduction or reconstruction of any portion of the licensing examination; or selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered licensing examination;

(b) standard of test administration including, but not limited to, improperly communicating with any other examinee during the administration of a licensing examination; copying answers from another examinee or permitting one’s own answers to be copied by another examinee during the administration of a licensing examination; or having in one’s possession during the administration of a licensing examination any books, notes, other written or printed materials, or data of any kind other than the examination materials or other materials authorized by the board; and

(c) credentials process including, but not limited to, falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination, impersonating an examinee, or having an impersonator take the licensing examination in one’s behalf.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

Prior Laws:1908 (25) 1083; Civ. C. ‘12 Section 1622; Civ. C. ‘22 Section 2404; 1920 (31) 1004; 1932 Code Section 5154; 1942 Code Section 5154; 952 Code Section 56‑1368; 1962 Code Section 56‑1368; 1976 Act No. 614, Section 2; 1983 Act No. 136, Section 1; 1988 Act No. 315, Section 1; 1993 Act No. 76, Section 3; 1993 Act No. 181, Section 921; 2005 Act No. 32, Section 10; 1976 Code Section 40‑47‑200.

**SECTION 40‑47‑111.** Disciplinary action in another state.

(A) Acts or omissions by a licensee causing the denial, cancellation, revocation, suspension, or restriction of a license to practice in another state, which would constitute misconduct in this State, support the issuance of a formal complaint and the commencement of disciplinary proceedings.

(B) Proof of acts or omissions in another state may be shown by a copy of the transcript of record of the disciplinary proceedings in that state or a copy of the final order, consent order, or similar order stating the basis for the action taken.

(C) Upon the filing of an application or an initial complaint alleging that the applicant or licensee has been disciplined in another state, the applicant or licensee must provide to the department copies of all transcripts, documents, and orders used, relied upon, or issued by the licensing authority in the other state. Failure to provide these items within ninety days of a written request results in the denial of the individual’s application or suspension of the individual’s authorization to practice in this State until these items have been provided to the department and until further order of the board.

(D) The applicant or licensee may present mitigating testimony to the board or hearing officer or hearing panel regarding disciplinary action taken in another state or evidence that the acts or omissions committed in another state do not constitute misconduct in this State.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑112.** Attending patient while under the influence of alcohol or drugs; penalty; suspension and disqualification from practice.

A person licensed or otherwise authorized by the Board of Medical Examiners who attends a patient while under the influence of alcohol or drugs is guilty of a misdemeanor and, upon conviction, may be fined not more than ten thousand dollars or imprisoned not more than one year. In addition, upon conviction, the license or authorization granted to the person must be suspended and the person must be disqualified from practicing in this State until he satisfies the board that he is qualified to resume practice. The provisions of this section are in addition to the remedies otherwise relating to physicians who may be addicted to the use of alcohol or drugs.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑113.** Establishment of physician‑patient relationship as prerequisite to prescribing drugs; unprofessional conduct.

(A) It is unprofessional conduct for a licensee initially to prescribe drugs to an individual without first establishing a proper physician‑patient relationship. A proper relationship, at a minimum, requires that the licensee make an informed medical judgment based on the circumstances of the situation and on the licensee’s training and experience and that the licensee:

(1) personally perform and document an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan;

(2) discuss with the patient the diagnosis and the evidence for it, and the risks and benefits of various treatment options; and

(3) ensure the availability of the licensee or coverage for the patient for appropriate follow‑up care.

(B) Notwithstanding subsection (A), a licensee may prescribe for a patient whom the licensee has not personally examined under certain circumstances including, but not limited to, writing admission orders for a newly hospitalized patient, prescribing for a patient of another licensee for whom the prescriber is taking call, prescribing for a patient examined by a licensed advanced practice registered nurse, a physician assistant, or other physician extender authorized by law and supervised by the physician, continuing medication on a short‑term basis for a new patient before the patient’s first appointment, or prescribing for a patient for whom the licensee has established a physician‑patient relationship solely via telemedicine so long as the licensee complies with Section 40‑47‑37 of this act.

(C) Prescribing drugs to individuals the licensee has never personally examined based solely on answers to a set of questions is unprofessional.

HISTORY: 2006 Act No. 385, Section 1; 2016 Act No. 210 (S.1035), Section 4, eff June 3, 2016.

Effect of Amendment

2016 Act No. 210, Section 4, rewrote (B), authorizing the prescription of medication as part of the practice of telemedicine and establishing limitations.

**SECTION 40‑47‑114.** Requiring professional competency, mental, or physical examination; request for review; obtaining records; confidentiality.

(A) If the board finds that probable cause exists that a licensee or applicant may be professionally incompetent, addicted to alcohol or drugs, or may have sustained a physical or mental disability that may render practice by the licensee or applicant dangerous to the public or is otherwise practicing in a manner dangerous to the public, the board, without a formal complaint or opportunity for hearing, may require a licensee or applicant to submit to a professional competency, mental, or physical examination by authorized practitioners designated by the board. The results of an examination are admissible in a hearing before the board, notwithstanding a claim of privilege under a contrary rule of law. A person who accepts the privilege of engaging in licensed practice in this State pursuant to this chapter, or who files an application for a license to practice pursuant to this chapter, is considered to have consented to submit to a professional competency, mental, or physical examination and to have waived all objections to the admissibility of the results in a hearing before the board upon the grounds that this constitutes a privileged communication. If a licensee or applicant fails to submit to an examination when properly directed to do so by the board, unless the failure was due to circumstances beyond the person’s control, the board shall enter an order automatically suspending or denying the license pending compliance and further order of the board. A licensee or applicant who is required to submit to a professional competency, mental, or physical examination may request by the close of the next business day after receipt of the requirement a review by the administrative hearing officer. Filing a written request for a review by the administrative hearing officer does not stay the time directed in which to submit to a professional competency, mental, or physical examination, and no stay may be issued, except as provided in this section. Upon proper written request, a review hearing must be conducted within three business days of receipt of the request, unless otherwise agreed by the parties. Failure to provide a review hearing within the prescribed time stays the time required to submit to a professional competency, mental, or physical examination until a decision is issued by the administrative hearing officer. The review hearing for purposes of this section must be limited to the issues of whether the person is a licensee or applicant, whether reasonable grounds exist to require a professional competency, mental, or physical examination, and whether the licensee or applicant has been informed that failure to submit to an examination will result in the entry of an order automatically suspending or denying the license pending compliance and further order of the board. The administrative hearing officer’s decision is not subject to appeal. A licensee or applicant who is prohibited from practicing pursuant to this subsection must be afforded at reasonable intervals an opportunity to demonstrate to the board the ability to resume or begin the practice with reasonable skill and safety.

(B) The board upon probable cause may obtain records relating to the professional competency or mental or physical condition of a licensee or applicant including, but not limited to, psychiatric records, which are admissible in a hearing before the board, notwithstanding any other provision of law. A person who accepts the privilege of engaging in licensed practice in this State pursuant to this chapter, or who files an application to practice pursuant to this chapter, is considered to have consented to the board obtaining these records and to have waived all objections to the admissibility of these records in a hearing before the board upon the grounds that this constitutes a privileged communication. If a licensee or applicant refuses to sign a written consent for the board to obtain these records when properly requested by the board, unless the failure was due to circumstances beyond the person’s control, the board shall enter an order automatically suspending or denying the license pending compliance and further order of the board. A licensee or applicant who is prohibited from practicing under this subsection must be afforded at reasonable intervals an opportunity to demonstrate to the board the ability to resume or begin the practice of medicine with reasonable skill and safety.

(C) An order requiring a licensee or applicant to submit to a professional competency, mental, or physical examination or an order requiring the submission of records relating to the professional competency or mental or physical condition of a licensee or applicant is confidential and must not be disclosed, except to the extent necessary for the proper disposition of the matter before the board or administrative hearing officer. The fact of automatic suspension or denial of a license pending compliance and further order of the board is public information under the Freedom of Information Act. A review hearing and decision of an administrative hearing officer are confidential, unless an order automatically suspending or denying a license pending compliance and further order of the board has been issued, in which case the fact of suspension or denial of a license by the administrative hearing officer is public information under the Freedom of Information Act.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑115.** Jurisdiction of the board.

The board has jurisdiction over the actions committed or omitted by current and former licensees as provided in Section 40‑1‑115.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑116.** Initial complaint; informal conference; approval of agreement.

(A) An initial complaint may be made by any person or the administrator of the board or director of the department based upon information considered reliable. The initial complaint must be dated, signed by the person making the complaint or the administrator or director when appropriate, and must identify the subject of the complaint and contain a brief summary of the nature of the complaint. Initial complaints must be filed with the director, or his designee, who may cause an investigation to be made into the allegation of professional misconduct. If the initial complaint on its face does not demonstrate an allegation of misconduct pursuant to this chapter, an investigation may not ensue. If the initial complaint does not demonstrate an allegation of misconduct pursuant to this chapter after investigation, the initial complaint may be dismissed. The department shall notify in writing the person initially complaining of the reason for dismissing the initial complaint. Except as provided in Section 40‑47‑190, the identity of the person making the initial complaint must remain privileged and confidential and must not be disclosed for use in any administrative or judicial proceeding of any kind. If a formal complaint is authorized, the identity of the initial complainant must continue to remain privileged and confidential, and must not be disclosed during the conduct of formal proceedings, upon administrative or judicial review, or at any time after that for use in any administrative or judicial proceeding of any kind, unless the initial complainant testifies as a witness in the formal proceedings.

(B) Before authorization of a formal complaint, the department shall provide an opportunity for the respondent to have an informal conference concerning the alleged misconduct with representatives of the department, including a physician designated by the board. The respondent may be represented by counsel at the conference, and the department shall so inform the respondent. Communications during the informal conference must be confidential. The parties shall maintain the confidentiality of the informal conference and shall not rely on, or introduce as evidence in any proceedings, any oral or written communications having occurred during the informal conference, unless such communications are obtained by means other than the informal conference. An agreement reached by the respondent and department must be documented in writing and signed by the respondent and the department and may provide for formal or informal disposition of the allegations, with or without admitting and denying misconduct. An agreement is not final until it has been submitted to and approved by the board. An agreement marked private must be placed in the respondent’s file within the department and maintained as confidential pursuant to Section 40‑47‑190(F).

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑117.** Formal complaint; service; answer; formal hearing by panel; filing of report with board; board action; notice.

(A) A formal complaint must be issued by the Office of General Counsel after investigation upon a finding by one or more physicians designated by the board that probable cause exists to believe that professional misconduct may have been committed. Formal complaints must be captioned “In the Matter of (name of respondent)” and signed by an attorney assigned or designated by the Office of General Counsel. The department shall cause to be sent to the respondent or counsel, if any, by certified mail a formal complaint setting forth in summary fashion the alleged misconduct together with a notice requiring that the respondent file with the department an answer to the formal complaint and to serve a copy of the answer upon the attorney assigned or designated by the Office of General Counsel within thirty days after the notice and formal complaint are mailed. The notice mailed to the respondent must state that if the respondent fails to answer, judgment by default may be taken against the respondent. The answer must be signed by the respondent or counsel or by both and may be verified. If no answer has been filed by the respondent or counsel after thirty calendar days from the date of receipt by the respondent of the notice and formal complaint and no extension has been granted, the allegations of the formal complaint must be considered admitted, and the board may proceed and render a default judgment against the respondent.

(B)(1) After the respondent’s answer has been filed, or the time within which the respondent was required to file the answer has expired, a formal hearing into the matter must be held by a panel of one lay member and not more than three physician members of the Medical Disciplinary Commission, none of which may reside or have a major part of their practice in the same county as the respondent. If the facts are not in dispute, the matter may be presented directly to the board for final decision without need for a panel hearing. The Office of General Counsel or its designee shall prepare and present the matter before the panel and board, as appropriate. Hearings must be held by the panel or board upon thirty days notice to the Office of General Counsel and the respondent or counsel.

(2) If the panel finds that the charges in the formal complaint are not supported by the evidence or do not merit taking disciplinary action, the panel shall make a certified report of the proceedings before it, including its findings of fact and conclusions of law, and shall file the report with the department.

(3) If the panel finds and determines that the respondent is guilty of misconduct, the panel shall submit a certified report of its proceedings, including its recommendation as to findings of fact, conclusions of law, and mitigating and aggravating circumstances for consideration by the board and shall file this report with the department together with a transcript of the testimony taken and the exhibits put into evidence before the panel. The panel may not recommend to the board whether a sanction should or should not be imposed.

(4) A copy of the panel’s report must be served upon the Office of General Counsel and the respondent or counsel.

(5) In the event of a tie vote by the panel, the matter must be presented to the board for final decision upon separate reports submitted by each side of the tie vote.

(C) When the panel has filed its report, the department shall notify the respondent or counsel, if any, of the time and place at which the board will consider the report for the purpose of determining its action on the report, the notice must be given not less than thirty days before the meeting. The respondent and the Office of General Counsel have the right to appear before the board and to submit briefs and be heard in oral argument in opposition to or in support of the recommendations of the panel.

(D) Upon consideration of the panel’s report and of the showing made to the board, the board may:

(1) refer the matter back to a panel for hearing;

(2) order a further hearing before the board; or

(3) proceed upon the certified report of the prior proceedings before the panel.

(E) Upon its final review, the board either may dismiss the complaint or find that the respondent is guilty of misconduct. If the formal complaint is dismissed, the department shall notify the respondent or counsel, if any, and the Office of General Counsel.

(F) If the board determines that the respondent is guilty of misconduct meriting sanction, the board shall issue a final order, including its findings of fact, conclusions of law, and decision of sanction, and shall file the report with the department, which promptly shall serve the respondent or counsel, if any, and the Office of General Counsel with a copy of the board’s final order.

(G) Service of notices conclusively must be presumed thirty days after mailing by first class or certified mail to the respondent to the last address provided to the board by the respondent.

(H) When provision is made for the service of any notice, order, report, or other paper or copy of these upon any person in connection with any proceeding, service may be made upon counsel of record for the person, either personally or by first class or certified mail.

(I) Service of notice upon a respondent who cannot be found at the last known address provided by the respondent may be made by leaving with the director, or his designee, a copy of the notice and any accompanying documents along with proof of attempted service at the last known address. The board may set aside and reopen a proceeding upon satisfactory showing by the respondent of good cause as to why the respondent did not receive service of the notice.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑118.** Discovery; exchange of information and evidence; depositions; prehearing motions.

(A) Discovery is not permitted in a medical disciplinary proceeding except as provided in this chapter. Within twenty days of an answer being filed, the Office of General Counsel, or its designee, and the respondent or counsel shall exchange the names and addresses of all persons known to have knowledge of the relevant facts. Except as provided in Section 40‑47‑190, the name and address of the initial complainant or a confidential informant must not be exchanged unless the person is expected to testify in the proceeding. The Office of General Counsel, or its designee, or the respondent or counsel may withhold information only with permission of the presiding officer, who shall authorize withholding of the information only for good cause shown, taking into consideration the materiality of the information possessed by the witness and the position the witness occupies in relation to the respondent. The presiding officer’s review of the withholding request must be en camera, but the party making the request shall advise the opposing party of the request without disclosing the subject of the request. The presiding officer shall set a date for the exchange of the names and addresses of all witnesses the parties intend to call at the hearing.

(B) The Office of General Counsel, or its designee, and respondent or counsel shall exchange:

(1) notwithstanding Section 40‑47‑190, evidence relevant to the formal charges, documents to be presented at the hearing and statements of witnesses who will be called at the hearing, except evidence privileged pursuant to other state law. For purposes of this item, a witness statement is a written statement signed or otherwise adopted or approved by the person making it or a stenographic, mechanical, electrical, or other recording, or a transcription of any of these, which is a substantially verbatim recital of an oral statement by the person making it and contemporaneously recorded; and

(2) other material only upon good cause shown to the presiding officer of the panel.

(C) Copies of transcripts of testimony taken by a court reporter pursuant to this section may be obtained by the parties from the court reporter at the expense of the requesting party and are not required to be made available to the requesting party by the opposing party unless not otherwise available.

(D) Depositions are only allowed if agreed upon by the Office of General Counsel, or its designee, and the respondent or counsel, or if the presiding officer grants permission to do so based upon a showing of good cause. The presiding officer may place restrictions or conditions on the manner, time, and place of an authorized deposition. Depositions must be completed not later than fifteen days before a scheduled hearing. A deposition request filed less than fifteen days before a scheduled hearing must not be granted absent a showing of exceptional circumstances.

(E) A party may take the deposition de bene esse of a supporting witness who will be unavailable to testify at hearing without order of the presiding officer and as a matter of right under due process of law. Other parties must be notified and afforded the opportunity to participate in the deposition de bene esse upon not less than ten days notice, unless sooner ordered by the presiding officer or agreed to by all participating parties. The admissibility of a deposition de bene esse or portion of the deposition must be determined by the presiding officer or board not less than five days prior to the time it is to be offered into evidence.

(F) Prehearing motions must be made to the presiding officer in writing and must state the grounds for relief and the relief sought. Motions pertaining to the hearing must be filed not later than ten days before the hearing date, unless otherwise ordered by the presiding officer. Any party may file a written response to the motion within five days unless the time is extended or shortened by the presiding officer.

(G) Notwithstanding any other provision of this section, the Office of General Counsel, or its designee, shall provide the respondent with exculpatory evidence relevant to the formal charges.

(H) Both parties have a continuing duty to supplement information required to be exchanged under this section.

(I) If a party fails to disclose timely a witness’s name and address, statements by the witness, or other evidence required to be disclosed or exchanged pursuant to this section, the panel or presiding officer may grant a continuance of the hearing, preclude the party from calling the witness or introducing the document, or take other action as may be appropriate. If the Office of General Counsel, or its designee, has not disclosed timely exculpatory material, the panel or presiding officer may require the matter to be disclosed and grant a continuance or take other action as may be appropriate.

(J) Disputes concerning depositions and the disclosure or exchange of information must be determined by the panel or presiding officer. Review of these decisions are not subject to an interlocutory appeal and must be challenged by filing objections to the panel’s report within fifteen days from the service of the report. Failure to file objections to the panel report constitutes acceptance of the ruling on the issue.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑119.** Information to be exchanged before hearing; admissibility; identification of relevant portions of information.

(A) Before the hearing the parties shall exchange:

(1) a final list of witnesses the party reasonably expects to testify at the hearing;

(2) a final list of all exhibits expected to be offered at the hearing, including a written report or summary from each expert witness expected to testify;

(3) a final list of all facts that the party intends to request be judicially noticed and the information supporting the judicial notice of the facts requested.

(B) A witness list or exhibit not exchanged before the hearing may be excluded from admission into evidence. The prehearing exchange may be amended upon motion and for good cause shown, unless the amendment would substantially prejudice any other party in the presentation of its case.

(C)(1) If at least twenty days written notice of the intention to offer the following documents is given to every party, accompanied by a copy of the document, the name of the author or maker of the document or other person who can establish its admissibility in evidence, a party may offer in evidence, without foundation or other proof:

(a) documents including, but not limited to, photographs, maps, drawings, blue prints, weather reports, business records, and communications;

(b) documents prepared by hospitals, doctors, dentists, registered nurses, and other health care providers; bills for drugs and medical appliances; property damages bills or estimates, if itemized, setting forth the charges for labor and materials; and reports of earnings and lost time prepared by an employer;

(c) the deposition of a witness;

(d) the written opinion of an expert, or the deposition of the expert if the expert’s qualifications, the subject of the expert testimony, the basis of the expert’s opinions and conclusions, and the expert’s opinions are also submitted at least twenty days before the hearing;

(e) any other document not specifically covered by any of the foregoing provisions which is otherwise admissible under the rules of evidence.

(2) Upon ten days notice to the proponent of the document and all other parties, any other party may subpoena the author, maker, or other person identified by the proponent who can establish the admissibility in evidence of a document admissible under this rule at that party’s expense and examine the author or maker as if under cross‑examination. If the properly subpoenaed author, maker, or other person identified by the proponent who can establish the admissibility of the document in evidence fails to appear at the hearing, or is beyond the jurisdiction of the subpoena and fails to appear at the hearing, the document is not admissible unless otherwise provided by the rules of evidence.

(3) Except as provided in this chapter, the established rules of evidence as provided in S.C. Code Ann. Section 1‑23‑330 (1976) must be followed. The presiding officer may require the submitting party to identify the portions of voluminous records or depositions that are relevant and material.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑120.** Sanctions; relinquishment of authorization to practice; issuance and notice of final orders.

(A) Upon determination by the board that one or more of the grounds for disciplinary action exists, the board may cancel, fine, suspend, revoke, issue a public reprimand or a private reprimand, or restrict, including probation or other reasonable action, such as requiring additional education or training or limitation on practice, the authorization to practice of a person who has engaged in misconduct.

(B) Upon ordering suspension, an action may be stayed upon terms and conditions as the board considers appropriate including, but not limited to, probation, payment of a fine, or other reasonable action, such as requiring additional education and training or limitation on practice.

(C) The board may require the licensee to pay a fine of up to twenty‑five thousand dollars and the costs of the disciplinary action. Fines are payable immediately upon the effective date of discipline unless otherwise provided by the board. Interest accrues after fines are due at the maximum rate allowed by law. No licensee against whom a fine is levied is eligible for reinstatement until the fine has been paid in full. Fines must be deposited in a special fund established for the department to defray the administrative costs associated with investigations and hearings pursuant to this chapter.

(D) A person whose authorization to practice has been permanently revoked never may be readmitted to practice in this State. A person whose authorization to practice has been revoked shall surrender within fifteen days after the effective date of the revocation the wall certificate and wallet card to the board administrator. The wall certificate and wallet card must be destroyed by the board administrator.

(E) A licensee may relinquish an authorization to practice instead of further disciplinary proceedings, subject to acceptance by the board chairman as being in the public interest. This action must be taken in writing on a form approved by the board. This action is irrevocable by the licensee upon signature by the licensee. Relinquishment must be given the same effect as a revocation of an authorization to practice and must be considered a public action under the Freedom of Information Act.

(F) Final orders of the board in a disciplinary proceeding must be issued upon approval of the board. Final orders must be kept on file in the board’s office and must be distributed as public orders of the board, except those designated as private reprimands or dismissals. Final orders, except those designated as private reprimands or dismissals, must be filed promptly with the Federation of State Boards of Medical Examiners and other national databases as required by law. A final order of the board, including those designated as private reprimands or dismissals, must be provided to the respondent.

(G) The fact of restriction of a licensee’s right to practice and subsequent related action is public information under the Freedom of Information Act. Orders to cease and desist issued against unlicensed persons are public information under the Freedom of Information Act.

(H) If a person’s license is suspended, reissued, or reinstated by the board for any reason, the board shall report that action to the licensee’s last known employer and, if applicable, to any place where the person has been granted privileges to practice.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

Prior Laws:1983 Act No. 136, Section 2; 1976 Code Section 40‑47‑201.

**SECTION 40‑47‑130.** Grounds for denial of licensure.

As provided in Section 40‑1‑130, the board may deny licensure to an applicant based on the same grounds for which the board may take disciplinary action against a licensee.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑140.** Denial of license based on prior criminal record.

A license may be denied based on a person’s prior criminal record only as provided in Section 40‑1‑140.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑150.** Surrender of license; public disclosure.

A licensee under investigation for a violation of this chapter or a regulation promulgated pursuant to this chapter voluntarily may surrender the license to practice in accordance with and subject to the provisions of Section 40‑1‑150. A person whose license is voluntarily surrendered may not practice or represent oneself to be authorized to practice until the board takes final action in the pending disciplinary matter. The voluntary surrender of the license is subject to public disclosure in accordance with Chapter 4 of Title 30. The board may credit the time that an authorization has been surrendered toward any period of suspension or other restriction of practice.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑160.** Appeal.

A respondent aggrieved by a final decision of the board may seek review of the decision to the Administrative Law Court in accordance with Section 40‑1‑160. Motions for continuance and for other interlocutory relief are not subject to review by the Administrative Law Court until a final decision has been issued by the board.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑170.** Costs.

A person found in violation of this chapter or regulations promulgated pursuant to this chapter may be required to pay costs associated with the investigation and prosecution of the case, including appeals, in accordance with Section 40‑1‑170.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑180.** Collection of fines and costs.

Costs and fines imposed pursuant to this chapter must be paid in accordance with and are subject to the collection and enforcement provisions of Section 40‑1‑180. No person against whom a fine is levied is eligible for the issuance or reinstatement of an authorization to practice until the fine has been paid in full.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑190.** Disclosure of information relating to proceedings; public access; information relating to patients and witnesses.

(A)(1) A person connected with any complaint, investigation, or other proceeding before the board including, but not limited to, a witness, counsel, counsel’s staff, board member, board employee, court reporter, or investigator may not mention the existence of the complaint investigation, or other proceeding, or disclose any information tending to identify the initial complainant or any witness or discuss testimony or other evidence in the complaint, investigation, or proceeding, except as otherwise provided in this section.

(2) Information may be disclosed to persons involved and having a direct interest in the complaint, investigation, or other proceeding to the extent necessary for the proper disposition of the complaint, investigation, or other proceeding. The name of the initial complainant must be provided to the licensee who is the subject of the complaint, investigation, or proceeding unless the board, hearing officer, or panel determines there is good cause to withhold that information.

(3) When the board receives information in any complaint, investigation, or other proceeding indicating a violation of state or federal law, the board may provide that information, to the extent the board considers necessary, to the appropriate state or federal law enforcement agency or regulatory body. The department may provide any information it considers necessary or appropriate to a substance abuse treatment program facility or monitoring program approved by the board, and this information must continue to be kept confidential and privileged from disclosure, except as provided by law.

(B) When a formal complaint is made regarding allegations of misconduct, the formal complaint and an answer must be available for public inspection and copying ten days after the answer is filed or if no answer is filed, ten days after the expiration of the time to answer. Once the formal complaint becomes available for public inspection and copying, subsequent records and proceedings relating to the misconduct allegations must be open to the public except as otherwise provided in this section.

(1) Patient records and identities must remain confidential unless the patient or legal representative of the patient consents in writing to the release of the records.

(2) If allegations of incapacity of a licensee due to physical or mental causes are raised in the complaint or answer, all records, information, and proceedings relating to those allegations of incapacity must remain confidential. Any order relating to the licensee’s authorization to practice must be made public; however, the order must not disclose the nature of the incapacity.

(C) Once a proceeding becomes public as provided in this section, there is a presumption that any hearing, other proceeding, or record must remain public unless a party to the proceeding makes a showing on the record before the board, hearing officer, or panel that closure of the hearing or the record, in whole or in part, is essential to protect patients, witnesses, or the respondent from unreasonable disclosure of personal or confidential information. Public notice must be given of the request or motion to close any portion of a hearing or record, and the board, hearing officer, or panel shall provide an opportunity for a person opposing the closure to be heard prior to the decision on closure being made.

(D) Subject to the right of public access and utilizing the procedure regarding closure described in this section, a witness in a proceeding or a patient whose care is at issue in a proceeding may petition the board, hearing officer, or panel for an order to close the hearing or record, in whole or part, to protect the witness or patient from unreasonable disclosure of personal or confidential information; however, the identity of a minor or sexual battery victim must remain confidential without a motion being made.

(E) Upon a finding on the record that the health or safety or the personal privacy of a witness or patient would be put at risk unreasonably by the public disclosure of identifying information or of other personal information, the board, hearing officer, or panel may issue an order to protect the witness or patient from the harm shown to be probable from public disclosure.

(F) Information that has been declared confidential or personal pursuant to this chapter or another applicable law must not be disclosed, except to the extent necessary for the proper disposition of the matter before the board, and is protected in the same manner as provided in Section 40‑71‑20, or as otherwise provided by law.

(G) Except as provided in this section, the identity of confidential informants or other witnesses who do not testify must be kept confidential and must not be disclosed to other parties, entities, or persons, and all information contained in confidential investigative files is privileged from disclosure for any reason whatsoever.

(H)(1) The department shall make reasonable efforts to provide written acknowledgment of every initial complaint and the disposition of the matter. Although entitled to notice, an initial complainant is not a party to the proceeding and is not entitled to appeal or otherwise seek review of the dismissal or other disposition of the matter.

(2) For every unauthorized disclosure of confidential or personal information by a person in violation of this chapter, the department may issue an administrative citation and may assess an administrative penalty of up to five hundred dollars per violation, not to exceed a total of ten thousand dollars per matter. Upon disclosure of confidential or personal information in violation of this chapter, the department may refuse to provide further information to the violator.

(3) An entity or individual assessed administrative penalties may appeal those penalties to the board within ten days of receipt of the citation. If an appeal is filed, the department shall schedule a hearing before the board, which shall make a determination in the matter. If no appeal is filed, the citation is considered a final order and the administrative penalties must be paid within thirty days of receipt of the citation or other written demand.

(I) No information in investigative files or disciplinary proceedings is required to be expunged pursuant to any other provision of state law.

(J) Every communication, oral or written, to the board, department, staff, counsel, expert reviewers or witnesses, or any other person acting on behalf of the board or department during the investigation, hearing, or adjudication of the disciplinary matters including, but not limited to, investigative reports concerning interviews and issues under investigation, correspondence, summaries, incident reports, computer printouts, and documents created during peer review proceedings are privileged from disclosure. Those persons and entities making such communications are immune from liability.

(K) Nothing in this chapter may be construed as prohibiting the respondent or the respondent’s counsel from exercising the respondent’s right of due process under the law or as prohibiting the respondent from access to the evidence relevant to the formal charges, documents to be presented at the hearing, and statements of witnesses who will be called at the hearing.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

Prior Laws:1962 Code Section 56‑1369.2; 1976 Code Section 40‑47‑212.

**SECTION 40‑47‑195.** Supervising physicians; scope of practice guidelines.

(A) A licensee who supervises another practitioner shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of their respective profession or shall hold an active unrestricted academic license to practice medicine in this State.

(B) Pursuant to this chapter, only licensed physicians may supervise another practitioner who performs delegated medical acts in accordance with the practitioner’s applicable scope of professional practice authorized by state law. It is the supervising physician’s responsibility to ensure that delegated medical acts to the APRN (NP, CNM, or CNS) or other practitioners are performed under approved written scope of practice guidelines or approved written protocol in accordance with the applicable scope of professional practice authorized by state law. A copy of approved written scope of practice guidelines or approved written protocol, dated and signed by the supervising physician and the practitioner, must be provided to the board by the supervising physician within seventy‑two hours of request by a representative of the department or board.

(C) In evaluating a written guideline or protocol, the board and supervising physician shall consider the:

(1) training and experience of the supervising physician;

(2) nature and complexity of the delegated medical acts being performed;

(3) geographic proximity of the supervising physician to the supervised practitioner; when the supervising physician is to be more than forty‑five miles from the supervised practitioner, special consideration must be given to the manner in which the physician intends to monitor the practitioner, and prior board approval must be received for this practice; and

(4) number of other practitioners the physician supervises. Reference must be given to the number of supervised practitioners, as prescribed by law. When the supervising physician assumes responsibility for more than the number of practitioners prescribed by law, special consideration must be given to the manner in which the physician intends to monitor, and prior board approval must be received for this practice.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑197.** Supervision of Certified Registered Nurse Anesthetist.

The physician or dentist responsible for the supervision of a certified registered nurse anesthetist (CRNA) must be identified on the anesthesia record before administration of anesthesia.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑200.** Practice without license or with license obtained by submitting false information; penalty.

A person who practices or offers to practice medicine in this State in violation of this chapter or who knowingly submits false information for the purpose of obtaining a license is guilty of a misdemeanor and, upon conviction, must be imprisoned not more than one year or fined not more than fifty thousand dollars. Each violation constitutes a separate offense. The provisions of this chapter apply to a person or entity aiding and abetting in a violation of this chapter.

HISTORY: 2006 Act No. 385, Section 1.

Editor’s Note

2005 Act No. 32, Section 7(B), provides as follows:

“(B) Upon approval by the Governor, this act takes effect July 1, 2005, for causes of action arising after July 1, 2005, except that as of this act’s effective date, the State Treasurer shall relinquish the management of funds in the Patients’ Compensation Fund, created pursuant to Section 38‑79‑420, to the Board of Governors of the fund, and premiums paid on or after this act’s effective date must be deposited with the Board of Governors of the fund. The fund must be fully transferred to the Board of Governors, and the State Treasurer may not hold any deposits of the fund as of ninety days after this act’s effective date.”

Prior Laws:Cr. C. ‘22 Section 390; 1920 (31) 1004; Civ. C. ‘22 Section 2415; 1932 Code Section 5165; 1942 Code Section 5165; 1952 Code Section 56‑1374; 1962 Code Section 56‑1374; 1970 (56) 2371; 1976 Code Section 40‑47‑260.

**SECTION 40‑47‑210.** Civil action for injunctive relief against person or entity violating chapter; fines.

The department, in addition to instituting a criminal proceeding, may institute a civil action through the Administrative Law Court for injunctive relief against a person or entity violating this chapter, a regulation promulgated pursuant to this chapter, or an order of the board. For each violation the administrative law judge may impose a fine of not more than ten thousand dollars.

HISTORY: 2006 Act No. 385, Section 1.

**SECTION 40‑47‑220.** Severability.

If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

HISTORY: 2006 Act No. 385, Section 1.

ARTICLE 5

South Carolina Respiratory Care Practice Act

**SECTION 40‑47‑500.** Short title.

This article is known and may be cited as the “South Carolina Respiratory Care Practice Act”.

HISTORY: 1986 Act No. 403, Section 2.

**SECTION 40‑47‑510.** Definitions.

As used in this article:

(1) “Board” means the Board of Medical Examiners of South Carolina.

(2) “Committee” means the Respiratory Care Committee which is established by this article as an advisory committee responsible to the board.

(3) “Respiratory care or respiratory therapy” means the allied health profession or specialty which provides educational, therapeutic, or diagnostic procedures utilized in the prevention, detection, and management of deficiencies or abnormalities, or both, of the cardiopulmonary systems.

(4) “Practice of respiratory care” may include, but is not limited to, the administration of pharmacologic, diagnostic, and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a physician; transcription and implementation of written or verbal orders of a physician pertaining to the practice of respiratory care; observing and monitoring the signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing including determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics and implementation, based on observed abnormalities or appropriate reporting, referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders of a person licensed to practice medicine under the laws of this State; or the initiation of emergency procedures under the regulations of the board or as otherwise permitted in this article. The practice of respiratory care may be performed in a clinic, hospital, skilled nursing facility, private dwelling, or other place considered appropriate or necessary by the board in accordance with the written or verbal order of a physician and must be performed under a qualified medical director.

(5) “Respiratory care practitioner” means a respiratory therapist or a respiratory therapy technician licensed to practice respiratory therapy who is a graduate of a school for respiratory therapy approved by the American Medical Association or a successor accrediting authority recognized as such by the board.

(6) “Medical director” means a physician licensed to practice medicine in South Carolina who has special interest and knowledge in the diagnosis, treatment, and assessment of respiratory problems. The practice of respiratory care or respiratory therapy must occur under the supervision of a qualified medical director. In the home care of cardiopulmonary patients, the existence of qualified physician sponsorship must be submitted and documented to the committee and approved by the board.

HISTORY: 1986 Act No. 403, Section 2; 1996 Act No. 223, Section 1. 1998 Act No. 280, Section 1.

**SECTION 40‑47‑520.** Licensing requirement.

Individuals practicing as respiratory therapists and respiratory therapy technicians employed to provide respiratory therapy procedures for inpatients, outpatients, and home patients must be licensed in accordance with this article.

HISTORY: 1986 Act No. 403, Section 2; 1998 Act No. 280, Section 2.

**SECTION 40‑47‑530.** Persons not subject to provisions of this article.

(A) This article does not affect:

(1) a person employed to provide respiratory care by the United States government if the person provides respiratory care solely under the direction or control of the organization by which the person is employed;

(2) a person actively pursuing a course of study leading to a degree or certificate in respiratory therapy in a program accredited by the American Medical Association or a successor accrediting authority recognized as such by the board if the activities and services constitute a part of a supervised course of study and if the person is designated by a title which clearly indicates the status of student;

(3) an individual or other health care professional who is licensed by the State or who has proven competency in one or more of the functions included in the definition of the practice of respiratory care as long as the person does not represent himself as a respiratory care practitioner. As it relates to respiratory care, individuals exempt pursuant to this section must provide proof of formal training for these functions which includes an evaluation of competence through a mechanism that is determined by the board and the committee to be both valid and reliable. The clinical assessment of artificial pressure adjuncts to the respiratory system may not be performed by any other person without proof of formal training and exemption by the board.

(4) a respiratory therapy student, active and in good standing, who may be employed and works under the direct supervision of a respiratory care practitioner and practices to the person’s level of proven clinical competency as certified by a program approved by the American Medical Association or a successor accrediting authority recognized as such by the board;

(5) employees of durable medical equipment companies delivering and setting up respiratory equipment in an individual’s home, pursuant to a written prescription by a physician, except that any instructions to the patient regarding the clinical use of the equipment, any patient monitoring, patient assessment or other procedures designed to evaluate the effectiveness of the treatment must be performed by a licensed respiratory care practitioner or other individual who is exempt by statute or regulation.

(B) Nothing in this article is intended to limit, preclude, or otherwise interfere with the practice of other persons and health providers formally trained and licensed by the appropriate agencies of this State.

HISTORY: 1986 Act No. 403, Section 2; 1996 Act No. 223, Section 2; 1998 Act No. 280, Section 3.

**SECTION 40‑47‑540.** Respiratory Care Committee created; membership.

There is created the Respiratory Care Committee as an advisory committee to the board which consists of nine members to be appointed by the board. Five of the members must be respiratory care practitioners with at least five years’ experience each, one member must be a consumer, and three members must be physicians who are licensed to practice in South Carolina who have special interest and knowledge in the diagnosis, treatment, and assessment of respiratory problems. All of the respiratory care practitioners must be certified except for the first members of the committee, who must be certified as soon after their appointment as possible. All organizations, groups, or interested individuals may submit recommendations to the board of at least two individuals for each position to be filled on the committee.

HISTORY: 1986 Act No. 403, Section 2.

**SECTION 40‑47‑550.** Terms of committee members; appointment and removal; expenses.

The members shall serve for terms of four years and until their successors are appointed and qualify, except that initial terms of two practitioners, the consumer member, and one physician, are for two years. Vacancies must be filled in the manner of the original appointment for the unexpired portion of a term. The board, after notice and opportunity for hearing, may remove any member of the committee for neglect of duty, incompetence, revocation or suspension of certification, or other dishonorable conduct. Members of the committee shall receive mileage, subsistence, and per diem provided by law for members of state boards, commissions, and committees for each meeting attended. No member may serve more than one full four‑year term consecutively, but he is eligible for reappointment two years from the date the full four‑year term expires.

HISTORY: 1986 Act No. 403, Section 2.

**SECTION 40‑47‑560.** Committee meetings; election of officers; recommendation, review, and approval of regulations.

The committee shall meet at least twice each year and at other times as its regulations provide. The quorum for meetings consists of five members with no more than three of these being respiratory care practitioners. At its initial meeting the committee shall elect from its membership a chairman, vice‑chairman, and a secretary to serve for one‑year terms. The committee may recommend regulations regarding respiratory care necessary to perform its duties which must be reviewed and approved by the board prior to adoption.

HISTORY: 1986 Act No. 403, Section 2.

**SECTION 40‑47‑570.** Employment of additional staff by director.

The Director of the Department of Labor, Licensing, and Regulation, pursuant to Section 40‑73‑15, may employ additional staff as necessary for the performance of its duties under this article.

HISTORY: 1986 Act No. 403, Section 2; 1993 Act No. 181, Section 923.

**SECTION 40‑47‑580.** Requirement that board receive and account for monies and pay them to State Treasurer.

The board shall receive and account for all monies collected under the provision of this article and shall pay the monies to the State Treasurer for deposit in the state general fund.

HISTORY: 1986 Act No. 403, Section 2.

**SECTION 40‑47‑590.** Responsibilities of committee; investigatory powers of board.

(A) The committee shall evaluate the qualifications and supervise the examinations of applicants for licensure and shall make appropriate recommendations to the board.

(B) The board may issue subpoenas, examine witnesses, and administer oaths, and may investigate allegations of practices violating the provisions of this article.

(C) The committee:

(1) shall recommend regulations to the board relating to professional conduct to carry out the policy of this article including, but not limited to, professional licensure and the establishment of ethical standards of practice for persons holding a license to practice respiratory care or respiratory therapy in this State;

(2) shall conduct hearings and keep records and minutes necessary to carry out its functions;

(3) shall provide notice of all hearings authorized under this article pursuant to the Administrative Procedures Act;

(4) shall determine the qualifications and make appropriate recommendations regarding the issuance of licenses to qualified respiratory care practitioners;

(5) shall recommend to the board whether to issue or renew licenses under those conditions prescribed in this article;

(6) may recommend continuing professional education to the board;

(7) shall keep a record of its proceedings and a register of all persons licensed. The register shall show the name of every registrant and the registrant’s last known place of employment and residence. The board annually shall compile and make available a list of respiratory care practitioners authorized to practice in this State. Any interested person may obtain a copy of this list upon application to the board and payment of an amount fixed by the board;

(8) shall make an annual report to the board containing an account of duties performed, actions taken, and appropriate recommendations;

(9) shall hear all disciplinary cases and recommend findings of fact, conclusions, and sanctions to the board. The board shall conduct a final order hearing at which it makes a final decision.

HISTORY: 1986 Act No. 403, Section 2; 1998 Act No. 280, Section 4.

**SECTION 40‑47‑600.** Requirements for certification of respiratory care practitioners.

An applicant for licensure as a respiratory care practitioner shall file a written application on forms provided by the board showing to the satisfaction of the committee and the board that the applicant has successfully passed the entry‑level examination given by the National Board for Respiratory Care, Inc., or other examination or requirement as the committee may administer or approve.

HISTORY: 1986 Act No. 403, Section 2; 1988 Act No. 541, Section 1; 1992 Act No. 422, Section 1; 1998 Act No. 280, Section 5.

**SECTION 40‑47‑610.** Licensure of practitioners of other states; educational and examination requirements.

(A) The board may license as a respiratory care practitioner, upon payment of the fee set by the board, an applicant who is a respiratory therapist or a respiratory therapy technician of another state, territory, or the District of Columbia, if the requirements were substantially equal to the requirements of this State as determined by the board;

(B) The committee initially shall waive the professional education and examination requirements and issue a license to any person who can demonstrate to the committee, through evidence verified under oath, that the person was employed as or actively performing the duties of a respiratory care practitioner in South Carolina in November and December of 1998; however, within three years of applying for initial licensure, the person must have complied with the educational and examination requirements provided for in Section 40‑47‑600. The applicants shall produce proof of high school graduation or the equivalent and shall apply within ninety days after public notification by the department.

HISTORY: 1986 Act No. 403, Section 2; 1998 Act No. 280, Section 6.

**SECTION 40‑47‑620.** Issuance of license by board.

The board shall issue a license to any person who meets the requirements of this article upon payment of the license fee.

HISTORY: 1986 Act No. 403, Section 2; 1998 Act No. 280, Section 7l.

**SECTION 40‑47‑625.** Temporary licenses.

The board may issue a temporary license if all licensing requirements have been met.

HISTORY: 1988 Act No. 541, Section 2; 1998 Act No. 280, Section 8.

**SECTION 40‑47‑630.** Grounds for disciplinary action; recommendations of committee as to disciplinary action; appeal.

(A) The committee may recommend to the board that it revoke, suspend, issue a public or private reprimand, or impose any other reasonable limitation or practice where the unprofessional, unethical, or illegal conduct of the respiratory care practitioner is likely to endanger the health, welfare, or safety of the public. This conduct includes a license:

(1) using any false, fraudulent, or forged statement or engaging in any fraudulent, deceitful, or dishonest act in connection with any of the certifying requirements;

(2) having an addiction to alcohol or drugs to such a degree as to render the licensee unfit to practice respiratory care;

(3) having been convicted of the illegal or unauthorized practice of respiratory care;

(4) knowingly performing an act which in any way assists an unlicensed person to practice respiratory care;

(5) having sustained any physical or mental disability which renders further practice by the licensee dangerous to the public;

(6) having violated the code of ethics or regulations as adopted by the committee and the board;

(7) guilty of engaging in any dishonorable, unethical, or unprofessional conduct that is likely to deceive or harm the public;

(8) guilty of the use of any false or fraudulent statement in any document connected with the practice of respiratory care;

(9) having intentionally violated or attempted to violate, directly or indirectly, or assisting in or abetting the violation or conspiring to violate any provisions of this article;

(10) guilty of the commission of any act, during the course of practice conducted pursuant to a license issued under this article, that constitutes fraud, dishonest dealing, illegality, incompetence, or gross negligence.

(B) The suspension, revocation, reprimand, or imposition of probationary conditions upon a respiratory care practitioner may be recommended by the committee to the board after a hearing is conducted in accordance with the Administrative Procedures Act. A transcribed record of the hearing must be made.

(C) A respiratory care practitioner aggrieved by a decision of the committee or board under this section may appeal the decision to an administrative law judge as provided under Article 5 of Chapter 23 of Title 1 on the record made before the committee or board.

HISTORY: 1986 Act No. 403, Section 2; 1993 Act No. 181, Section 924; 1998 Act No. 280, Section 9.

**SECTION 40‑47‑640.** Renewal and reinstatement of licenses.

(A) Licenses issued under this article are subject to annual renewal and expire unless renewed in the manner prescribed by the regulations of the committee. The committee may recommend additional requirements for license renewal which provide evidence of continued competency. The board may provide for the late renewal of a license upon payment of a late fee.

(B) An inactive license is subject to expiration and may be renewed as provided in this section, but renewal does not entitle the respiratory care practitioner, while the license remains inactive, to engage in the certified activity of respiratory therapy. If a certificate suspended on disciplinary grounds is reinstated, the respiratory care practitioner, as a condition of reinstatement, shall pay the renewal fee and any applicable late fee.

HISTORY: 1986 Act No. 403, Section 2; 1998 Act No. 280, Section 10.

**SECTION 40‑47‑650.** Fees.

The board and the committee shall prescribe fees in amounts recommended by the committee for:

(1) initial licensure, not to exceed two hundred dollars;

(2) renewal of license fee, not to exceed fifty dollars;

(3) late renewal fee, not to exceed double renewal fee.

The fees must be set in such an amount as to reimburse the State to the extent feasible for the cost of the services rendered by the board.

HISTORY: 1986 Act No. 403, Section 2; 1998 Act No. 280, Section 11.

**SECTION 40‑47‑655.** Limited license to practice respiratory care.

(A) Upon payment of a fee prescribed by the committee and approved by the board, the board may issue a limited license to practice respiratory care under the direct supervision of a licensed respiratory care practitioner to an applicant who presents written documentation, verified by oath, that the applicant is a graduate of or student of a respiratory care program approved by the American Medical Association or a successor accrediting authority recognized as such by the board. If a student, the applicant must be scheduled to graduate from this program within forty‑five days of the date on which the limited license is to be issued.

(B) A limited license issued under this section is valid for a period of six months. Upon expiration of a limited license and payment of the fee prescribed by the committee and approved by the board, the board may renew the limited license once for a period of six months. A limited license must not be renewed more than twelve months from the date it was originally issued.

HISTORY: 1988 Act No. 337; 1988 Act No. 541, Section 3; 1996 Act No. 223, Section 3; 1998 Act No. 280, Section 12.

**SECTION 40‑47‑660.** Enforcement of article.

(A) It is unlawful for any person who is not licensed under this article to hold himself out as a respiratory care practitioner, respiratory therapist, or a respiratory therapy technician. A person who holds himself out or practices as a respiratory care practitioner without being licensed under this article, during a period of suspension, or after his certificate has been revoked by the board is guilty of a misdemeanor and, upon conviction, must be fined not more than three hundred dollars or imprisoned for not more than ninety days, or both.

(B) For the purpose of an investigation or proceeding under this article, the board or a person designated by it may administer oaths and affirmations, subpoena witnesses, take testimony, and require the production of documents or records which the board considers relevant to the inquiry. In the case of contumacy by, or refusal to obey a subpoena issued to a person, an administrative law judge as provided under Article 5 of Chapter 23 of Title 1, upon application by the board, may issue an order requiring the person to appear before the board or the person designated by it, produce documentary evidence, and give other evidence concerning the matter under inquiry.

When the board has sufficient evidence that a person is violating any provisions of this article, it may, in addition to all other remedies, order the person to immediately desist and refrain from this conduct. The board may apply to an administrative law judge as provided under Article 5 of Chapter 23 of Title 1 for an injunction restraining the person from this conduct. An administrative law judge may issue a temporary injunction ex parte and upon notice and full hearing may issue any other order in the matter it considers proper. No bond may be required of the board by an administrative law judge as a condition to the issuance of any injunction or order contemplated by the provisions of this section.

(C) Every communication, whether oral or written, made by or on behalf of a person or firm to the board or any person designated by it to investigate or otherwise hear matters relating to the revocation, suspension, or other restriction on a license or other discipline of a licensee, whether by way of complaint or testimony, is privileged. No action or proceeding, civil or criminal, may lie against the person or firm for the communication except upon proof that the communication was made with malice.

(D) No provision of this article may be construed as prohibiting the respondent or his legal counsel from exercising the respondent’s constitutional right of due process under the law nor prohibiting the respondent from normal access to the charges and evidence filed against him as a part of due process under the law.

HISTORY: 1986 Act No. 403, Section 2; 1993 Act No. 181, Section 925; 1998 Act No. 280, Section 13.

ARTICLE 6

Acupuncture Act of South Carolina

**SECTION 40‑47‑700.** Citation of article.

This article may be cited as the “Acupuncture Act of South Carolina”.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑705.** Definitions.

For purposes of this article:

(1) “Acupuncture” means a form of health care developed from traditional and modern oriental concepts for health care that employs oriental medical techniques, treatment, and adjunctive therapies for the promotion, maintenance, and restoration of health and the prevention of disease. The practice of acupuncture does not include:

(a) osteopathic medicine and osteopathic manipulative treatment;

(b) “chiropractic” or “chiropractic practice” as defined in Section 40‑9‑10; or

(c) “physical therapy” as defined in Section 40‑45‑20 or therapies allowed as part of the practice of physical therapy.

(2) “Auricular (ear) detoxification therapy” means the insertion of disposable sterile acupuncture needles into the five auricular acupuncture points stipulated by the National Acupuncture Detoxification Association protocol for the sole purpose of treatment of chemical dependency, detoxification, and substance abuse.

(3) “Board” means the State Board of Medical Examiners.

(4) “Committee” means the Acupuncture Advisory Committee as established by this article as an advisory committee responsible to the board.

(5) “NADA” means the National Acupuncture Detoxification Association.

(6) “NCAAOM” means the National Certification Commission for Acupuncture and Oriental Medicine.

(7) “ACAOM” means Accreditation Commission for Acupuncture and Oriental Medicine.

(8) “Auricular therapy” means the insertion of disposable needles into and limited only to the ear, to treat a limited number of conditions.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑710.** Acupuncture Advisory Committee; membership; terms; filling vacancies; removal of members; meeting schedule; officers.

(A) There is established the Acupuncture Advisory Committee to be composed of five members to be appointed by the Board of Medical Examiners for terms of four years and until their successors are appointed and qualify. Three members must be licensed to practice acupuncture under this article; one of whom has practiced acupuncture for a minimum of three years; one member must be licensed to practice medicine under this chapter and may be an acupuncturist; and one member must be from the State at large. The advisory committee members shall receive mileage, per diem, and subsistence as provided by law for members of state boards, committees, and commissions and have such responsibilities as provided for in this article and as the board may determine.

(B) Vacancies must be filled in the manner of the original appointment for the unexpired portion of the term. The board, after notice and opportunity for hearing, may remove any member of the committee for negligence, neglect of duty, incompetence, revocation or suspension of license, or other dishonorable conduct. No member may serve more than two full four‑year terms consecutively but may be eligible for reappointment four years from the date the last full four‑year term expired.

(C) The committee shall meet at least two times yearly and at other times as may be necessary. Four members constitute a quorum. At its initial meeting, and at the beginning of each year thereafter, the committee shall elect from its membership a chairman, vice chairman, and secretary to serve for a term of one year.

(D) The committee shall receive and account for all monies under the provisions of this article and shall pay all monies collected to the board for deposit with the State Treasurer as provided for by law.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑715.** Powers and duties.

(A) The committee may:

(1) recommend regulations to the board relating to professional conduct to carry out the provisions of this article including, but not limited to, professional certification and the establishment of ethical standards of practice for persons holding a license to practice as acupuncturists, auricular therapists, and auricular detoxification specialists in this State;

(2) recommend requirements to the board for continuing professional education acupuncturists, auricular therapists, and auricular detoxification specialists to the board;

(3) request and receive the assistance of state educational institutions or other state agencies and recommend to the board information of consumer interest describing the regulatory functions of the advisory committee and the procedures by which consumer complaints are filed with and resolved by the board. The board shall make the information available to the public and appropriate state agencies.

(B) The committee shall:

(1) conduct hearings and keep records and minutes necessary to carry out its functions;

(2) provide notice of all hearings authorized under this article pursuant to the Administrative Procedures Act;

(3) determine the qualifications and make recommendations regarding the issuance of licenses to qualified acupuncturists, auricular therapists, and auricular detoxification specialists;

(4) recommend to the board whether to issue or renew licenses under those conditions prescribed in this article;

(5) keep a record of its proceedings and a register of all licensees, including their names and last known places of employment and residence. The board shall annually compile and make available a list of acupuncturists, auricular therapists, and auricular detoxification specialists authorized to practice in this State. An interested person may obtain a copy of this list upon application to the board and payment of an amount sufficient to cover the cost of printing and mailing;

(6) report annually to the board on duties performed, actions taken, and recommendations made;

(7) hear disciplinary cases and recommend findings of fact, conclusions of law, and sanctions to the board. The board shall conduct a final hearing at which it shall make a final decision;

(8) perform such duties and tasks as may be delegated to the committee by the board.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑720.** License to practice acupuncture; requirements and qualifications; temporary licenses.

(A) Each applicant for a license to practice acupuncture shall:

(1) submit a completed application as prescribed by the board;

(2) submit fees as provided for in Section 40‑47‑800;

(3) hold an active certification in acupuncture by the National Commission for the Certification of Acupuncturists and Oriental Medicine;

(4) be of good moral character;

(5) not have pled guilty or nolo contendere to or been convicted of a felony or crime of moral turpitude.

(B) The application must be complete in every detail before it may be approved. When the administrative staff of the board has reviewed the entire application for completeness and correctness, has found the applicant eligible, and the applicant has appeared before the committee or a designated board member, a temporary license may be issued. At the next committee meeting the entire application must be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑725.** Licensing of current acupuncture practitioners.

(A)(1) An acupuncturist who is currently approved by the board to practice acupuncture in this State, who has remained in good standing, and who has successfully completed a nationally recognized clean needle technique course approved by the board must receive initial licensure under this article after submitting:

(a) a completed application as prescribed by the board;

(b) fees as provided for in Section 40‑47‑800.

(2) However, a license issued pursuant to subsection (A)(1) is only valid for two years. Thereafter for license renewal, the individual must hold an active certification from the National Commission for the Certification of Acupuncture and Oriental Medicine and satisfy the licensure and renewal requirements prescribed in this article.

(B) An individual who has continuously practiced acupuncture in this State since 1980, who has remained in good standing, must be issued a license and renewal licenses without meeting the requirements of this chapter after submitting:

(1) a completed application as prescribed by the board; and

(2) fees as provided for in Section 40‑47‑800.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑730.** Licenses to perform auricular therapy; qualifications; temporary licenses.

(A) An applicant for a license to perform auricular therapy:

(1) must be twenty‑one years of age;

(2) shall submit a completed application as prescribed by the medical board;

(3) shall submit fees as provided for in Section 40‑47‑800;

(4) shall provide evidence of certification as having been trained to utilize auricular points only, in addition to those utilized by a detoxification specialist;

(5) successful completion of a national certified program approved by the Acupuncture Advisory Committee and the State Board of Medical Examiners;

(6) successful completion of a Clean Needle Technique course approved by the board.

(B) The application must be complete in every detail before it may be approved. When the administrative staff of the board has reviewed the entire application for completeness and correctness, has found the applicant eligible, and the applicant has appeared before the committee or a designated board member, a temporary license may be issued. At the next committee meeting the entire application must be considered, and if qualified, the committee may recommend to the board that a permanent license be issued, if the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑735.** Licenses to perform auricular detoxification therapy; qualifications; temporary licenses.

(A) An applicant for a license to perform auricular detoxification therapy:

(1) must be at least twenty‑one years of age;

(2) shall submit a completed application as prescribed by the board;

(3) shall submit fees as provided for in Section 40‑47‑800;

(4) shall have successfully completed a nationally recognized training program in auricular detoxification therapy for the treatment of chemical dependency detoxification and substance abuse, as approved by the board;

(5) shall have successfully completed a nationally recognized clean needle technique course approved by the board.

(B) The application must be complete in every detail before it may be approved. When the administrative staff of the board has reviewed the entire application for completeness and correctness, has found the applicant eligible, and the applicant has appeared before the committee or a designated board member, a temporary license may be issued. At the next committee meeting the entire application must be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑740.** Licensing of current auricular therapists or auricular detoxification specialists.

(A) An auricular therapist or an auricular detoxification specialist who is currently approved by the board to practice in this State, who has remained in good standing, and who has successfully completed a nationally recognized clean needle technique course approved by the board must receive initial licensure under this article after submitting:

(1) a completed application as prescribed by the board;

(2) fees as provided for in Section 40‑47‑800.

(B) However, a license issued pursuant to subsection (A) is only valid for two years. Thereafter for license renewal the individual must have successfully passed a board‑approved nationally recognized training program in auricular therapy or auricular detoxification and satisfy the licensure requirements prescribed in this article.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑745.** Unauthorized practice; penalty; cease and desist orders and injunctions; privileged communications.

(A) It is unlawful for a person not licensed under this article to hold himself out as an acupuncturist, auricular therapist, or auricular detoxification specialist. The titles “Licensed Acupuncturist” (L.Ac.) and “Acupuncturist” may only be used by a person licensed to practice acupuncture pursuant to this article. Further, a person licensed to practice auricular therapy or auricular detoxification may not practice acupuncture or hold himself out as an acupuncturist. The title “Auricular Detoxification Specialist” (ADS) may only be used by a person licensed to practice auricular detoxification therapy pursuant to this article. Possession of a license as an auricular therapist or an auricular detoxification specialist does not, by itself, entitle a person to identify himself or herself as an acupuncturist. A person who holds himself out as an acupuncturist, auricular therapist, or auricular detoxification specialist without being licensed pursuant to this article, during a period of suspension, or after his or her license has been revoked by the board is guilty of a misdemeanor and, upon conviction, must be fined not more than three hundred dollars or imprisoned not more than ninety days, or both.

(B) For the purpose of any investigation or proceeding under this article, the board or a person designated by the board may administer oaths and affirmations, subpoena witnesses, take testimony, and require the production for any documents or records which the board considers relevant to the inquiry.

(C) If the board has sufficient evidence that a person is violating a provision of this article, the board, in addition to all other remedies, may order the person to immediately cease and desist from this conduct. The board may apply to an administrative law judge as provided under Article 5, Chapter 23 of Title 1 for an injunction restraining the person from this conduct. An administrative law judge may issue a temporary injunction ex parte and upon notice and full hearing may issue any other order in the matter it considers proper. No bond may be required of the board by an administrative law judge as a condition to the issuance of an injunction or order contemplated by the provisions of this section.

(D) Each communication, whether oral or written, made by or on behalf of a person or firm to the board or a person designated by the board to investigate or otherwise hear matters relating to the revocation, suspension, or other restriction on a license or other discipline of a license holder, whether by way of complaint or testimony, is privileged and exempt from disclosure for any reason except to the extent disclosed in proceedings before the board. No action or proceeding, civil or criminal, may lie against the person or firm for the communication except upon other proof that the communication was made with malice.

(E) No provision of this article may be construed as prohibiting the respondent or his legal counsel from exercising the respondent’s constitutional right of due process under the law or prohibiting the respondent from normal access to the charges and evidence filed against him as part of due process under the law.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑750.** Auricular therapy defined; supervision.

Auricular therapy may take place under the supervision of a licensed acupuncturist or a person licensed to practice medicine under this chapter. A treatment by an auricular therapist is strictly limited to inserting needles into the ear. Inserting needles anywhere else on the body is considered practicing acupuncture without a license.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑755.** Auricular detoxification therapy defined; supervision.

Auricular detoxification therapy may take place under the direct supervision of a licensed acupuncturist or a person licensed to practice medicine under this chapter. A treatment by an auricular detoxification specialist is strictly limited to the five ear‑point treatment protocol for detoxification, substance abuse, or chemical dependency as stipulated by NADA.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑760.** Exempted activities.

This article does not apply to:

(1) the practice of acupuncture if it is an integral part of the program of study by students enrolled in an acupuncture education program under the direct clinical supervision of a licensed acupuncturist with at least five years of clinical experience and the program is accredited or is a candidate for accreditation or is actively seeking accreditation from ACAOM;

(2) a person employed as an acupuncturist or an auricular detoxification specialist by the United States Government if these services are provided solely under the direction or control of the United States Government.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑765.** Grounds for revocation, suspension, or denial of license.

Misconduct constituting grounds for revocation, suspension, probation, reprimand, restrictions, or denial of a license must be found when an acupuncturist, auricular therapist, or auricular detoxification specialist:

(1) has knowingly allowed himself or herself to be misrepresented as a medical doctor;

(2) has filed or has had filed on his or her behalf with the board any false, fraudulent, or forged statement or documents;

(3) has performed any work assignment, task, or other activity which is outside the scope of practice of licensure;

(4) misuses alcohol or drugs to such a degree to render him or her unfit to practice;

(5) has been convicted of a felony or a crime involving moral turpitude or drugs;

(6) has sustained any physical or mental disability which renders further practice dangerous to the public;

(7) has engaged in any dishonorable or unethical conduct that is likely to deceive or harm patients;

(8) has used or made any false or fraudulent statement in any document connected with practice or licensure;

(9) has obtained or assisted another person in obtaining fees under dishonorable, false, or fraudulent circumstances;

(10) has violated or conspired with another person to violate any provision of this article;

(11) otherwise demonstrates a lack of the ethical or professional competence required to practice;

(12) has failed to refer to a licensed medical doctor or dentist, as appropriate, a patient whose medical condition should have been determined to be beyond their scope of practice; or

(13) continues to provide acupuncture, auricular detoxification therapy, or auricular therapy services to any patient who the licensee treats at least one time per month for three consecutive months, and has not demonstrated clinical improvement, unless the licensee provides the patient with written notice, on or before the expiration of the third month, that the patient may need to seek a medical diagnosis from a licensed medical doctor or dentist before continuing with acupuncture, auricular detoxification therapy, or auricular therapy services, unless the patient was referred to the licensee by a licensed medical doctor or dentist.

Upon a finding of misconduct, the board may impose any sanction that the board is otherwise authorized to impose for misconduct under this chapter.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑770.** Inspections.

The board or a person designated by the board may make unscheduled inspections of any office or facility employing an acupuncturist or auricular detoxification specialist.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑775.** Display of license.

A person who holds a license issued in accordance with this article and who is engaged in the active practice of acupuncture, or the active practice of auricular therapy or the active practice of auricular detoxification, shall display the license in an appropriate and conspicuous location in the person’s place of practice.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑780.** Renewal of licenses.

(A) An acupuncture license issued under this article must be renewed biennially if the person holding the license:

(1) submits a completed license renewal application as prescribed by the board;

(2) submits the applicable fees provided for in Section 40‑47‑800;

(3) is not in violation of this article at the time of application for renewal;

(4) fulfills requirements for continuing education and professional development, as prescribed by the board in regulation;

(5) remains actively certified by the NCCAOM.

(B) An auricular therapist or auricular detoxification specialist license issued under this article must be renewed biennially if the person holding the license:

(1) submits a completed license renewal application prescribed by the board;

(2) submits the applicable fees provided for in Section 40‑47‑800;

(3) is not in violation of this article or any regulation promulgated under this article at the time of application for renewal;

(4) fulfills requirements for continuing education and professional development as prescribed by the board in regulation;

(5) remains active in the practice of auricular therapy or auricular detoxification.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑785.** Request for inactive status.

Under procedures and conditions established by the board, a license holder may request that his or her license be declared inactive. The licensee may apply for active status at any time and, upon meeting the conditions established by the board in regulation, may be declared active.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑790.** Licensee not to hold himself or herself out as authorized to practice medicine.

No person licensed under this article may advertise or hold himself or herself out to the public as being authorized to practice medicine under this chapter.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑800.** Licensing fees.

Fees for acupuncturist, auricular therapist, and auricular detoxification specialist licensure must be established and adjusted biennially in accordance with Section 40‑1‑50(D) to ensure that they are sufficient but not excessive to cover expenses including the total of the direct and indirect costs to the State for the operations of the committee:

(1) initial licensing fee;

(2) renewal of license fee;

(3) late renewal fee;

(4) reactivation application fee.

HISTORY: 2005 Act No. 10, Section 1.

**SECTION 40‑47‑810.** Third party reimbursement.

Nothing in this article may be construed to require third party reimbursement directly to an acupuncturist, auricular therapist, or auricular detoxification specialist for services rendered.

HISTORY: 2005 Act No. 10, Section 1.

ARTICLE 7

South Carolina Physician Assistants Practice Act

**SECTION 40‑47‑905.** Short title.

This article may be cited as the “South Carolina Physician Assistants Practice Act”.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑910.** Definitions.

As used in this article:

(1) “Alternate physician supervisor” or “alternate supervising physician” means a South Carolina licensed physician currently possessing an active, unrestricted permanent license to practice medicine in South Carolina who accepts the responsibility to supervise a physician assistant’s activities in the absence of the supervising physician and this physician is approved by the physician supervisor in writing in the scope of practice guidelines.

(2) “Board” means the Board of Medical Examiners of South Carolina.

(3) “Committee” means the Physician Assistant Committee as established by this article as an advisory committee responsible to the board.

(4) “Immediate consultation” means a supervising physician must be available for direct communication by telephone or other means of telecommunication.

(5) “NCCPA” means the National Commission on Certification of Physician Assistants, Inc., the agency recognized to examine and evaluate the education of physician assistants, or its successor organization as recognized by the board.

(6) “Physician assistant” means a health care professional licensed to assist in the practice of medicine with a physician supervisor.

(7) “Physician supervisor” or “supervising physician” means a South Carolina licensed physician currently possessing an active, unrestricted permanent license to practice medicine in South Carolina who is approved to serve as a supervising physician for no more than three full‑time equivalent physician assistants. The physician supervisor is the individual who is responsible for supervising a physician assistant’s activities.

(8) “Supervising” means overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant as part of a physician‑led team in a manner approved by the board.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 1; 2013 Act No. 28, Section 2, eff May 21, 2013.

Effect of Amendment

The 2013 amendment added subsection (4), the definition of “Immediate consultation”; redesignated former subsections (4) through (7) as (5) through (8); in subsection (7), substituted “three full‑time equivalent physician assistants” for “two physician assistants”; and in subsection (8), inserted “as part of a physician‑led team”.

**SECTION 40‑47‑915.** Application of article.

This article does not apply to a person:

(1) who is employed as a physician assistant by the United States Government, where such services are provided solely under the direction or control of the United States Government.

(2) pursuing a course of study leading to a degree or certificate to practice as a physician assistant in a program approved by the Commission on Accreditation of Allied Health Education Programs or its successor agency, where such activities and services constitute a part of a supervised course of study; however, the person must be clearly identified by a badge or other adornment with that person’s name and the words “Physician Assistant‑Student” clearly legible. The badge or adornment must be at least one inch by three inches in size.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑920.** Authority to employ staff.

The Director of the Department of Labor, Licensing and Regulation may employ additional staff as necessary for the performance of the department’s duties under this article.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑925.** Physician Assistant Committee; membership; term; filling vacancies; meetings; duty to receive and account for monies collected under article.

(A) There is created the Physician Assistant Committee as an advisory committee to the board which consists of nine members to be appointed by the Board of Medical Examiners. Three of the members must be licensed physician assistants with a minimum of three years of patient care experience in this State. Two members must be consumers, and three members must be physicians who are licensed to practice in this State. Of the three physician members, at least one must regularly employ a physician assistant. One member of the Board of Medical Examiners shall serve on the committee ex officio. All organizations, groups, or interested individuals may submit recommendations to the board of at least two individuals for each position to be filled on the committee.

(B) The members shall serve for terms of four years and until their successors are appointed and qualify, except the initial term of two physician assistants, the consumer member, and one physician are for two years. Vacancies must be filled in the manner of the original appointment for the unexpired portion of the term. The board, after notice and opportunity for hearing, may remove any member of the committee for negligence, neglect of duty, incompetence, revocation or suspension of license, or other dishonorable conduct. Members of the committee shall receive mileage, subsistence, and per diem as provided by law for members of state boards, commissions, and committees for each meeting attended. No member may serve more than two full four‑year terms consecutively, but may be eligible for reappointment four years from the date the last full four‑year term expired.

(C) The committee shall meet at least two times yearly and at other times as may be necessary. A quorum for all meetings shall consist of five members. At its initial meeting, and at the beginning of each year thereafter, the committee shall elect from its membership a chairman, vice‑chairman, and secretary to serve for a term of one year.

(D) The committee shall receive and account for all monies under the provisions of this article and shall pay all monies collected to the board for deposit with the State Treasurer as provided for by law.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑930.** Powers and duties of committee and board.

(A) The committee shall evaluate the qualifications and supervise the examinations of applicants for licensure and make recommendations to the board.

(B) The board may issue subpoenas, examine witnesses, and administer oaths and may investigate allegations of practices violating the provisions of this article.

(C) The committee:

(1) may recommend regulations to the board relating to professional conduct to carry out the provisions of this article including, but not limited to, professional certification and the establishment of ethical standards of practice for persons holding a license to practice as physician assistants in this State;

(2) shall conduct hearings and keep records and minutes necessary to carry out its functions;

(3) shall provide notice of all hearings authorized under this article pursuant to the Administrative Procedures Act;

(4) shall determine the qualifications and make recommendations regarding the issuance of licenses to qualified physician assistants;

(5) shall recommend to the board whether to issue or renew licenses under those conditions prescribed in this article;

(6) may recommend requirements to the board for continuing professional education of physician assistants to the board;

(7) shall keep a record of its proceedings and a register of all licensees, including their names and last known places of employment and residence. The board shall annually compile and make available a list of physician assistants authorized to practice in this State. An interested person may obtain a copy of this list upon application to the board and payment of an amount sufficient to cover the cost of printing and mailing;

(8) shall report annually to the board on duties performed, actions taken, and recommendations;

(9) shall hear disciplinary cases and recommend findings of fact, conclusions of law, and sanctions to the board. The board shall conduct a final hearing at which it shall make a final decision;

(10) shall perform such duties and tasks as may be delegated to the committee by the board.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑935.** Act and duties physician assistant authorized to perform; agency relationship to supervising physician.

Physician assistants may perform:

(1) medical acts, tasks, or functions with written scope of practice guidelines under physician supervision;

(2) those duties and responsibilities, including the prescribing and dispensing of drugs and medical devices, that are lawfully delegated by their supervising physicians. However, only physician assistants holding a permanent license may prescribe drug therapy as provided in this article.

A physician assistant is an agent of his or her supervising physician in the performance of all practice related activities including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 2.

**SECTION 40‑47‑938.** Supervisory relationships.

(A) A physician currently possessing an active, unrestricted permanent license to practice medicine under the provisions of this chapter, who accepts the responsibility to supervise a physician assistant’s activities, must enter into a supervisory relationship with a physician assistant licensed pursuant to this article, subject to approval of scope of practice guidelines by the board. The physician must notify the board, in writing, of the proposed supervisory relationship and include the proposed scope of practice guidelines for the relationship. Upon receipt of board approval, the physician assistant may begin clinical practice with the named supervising physician and alternate physicians.

(B) A supervising physician may determine that there are additional medical acts, tasks, or functions for which a physician assistant under the physician’s supervision needs additional training or education to meet the needs of the physician’s practice and that the physician would like to incorporate into the physician assistant’s scope of practice guidelines. The physician must determine, in consultation with the physician assistant, the means of educating the physician assistant, which may include training under the direct supervision of the physician, education, or certification of proposed practices or other appropriate educational methods. The physician must notify the board in writing of the requested changes to the physician assistant’s scope of practice guidelines and must provide documentation to the board of the competence of the physician assistant to perform the additional medical acts, tasks, or functions. Upon receipt of board approval of the requested changes, the physician assistant may incorporate these additional medical acts, tasks, or functions into practice.

(C) The board shall review and determine whether to approve these proposed scope of practice guidelines or requested changes to the scope of practice guidelines within ten business days after receipt of notice from the supervising physician as required by subsections (A) and (B). If the board needs additional information or clarification, a physician member of the board must contact the supervisory physician within ten business days of receipt of the physician’s notice. If the board requests additional information or clarification to consider approval of scope of practice guidelines or changes to these guidelines, the supervising physician shall provide it in a timely manner; and upon receipt, a determination regarding approval must be made within ten business days.

HISTORY: 2013 Act No. 28, Section 1, eff May 21, 2013.

**SECTION 40‑47‑940.** Application for license; appearance before committee; temporary and permanent licenses.

(A) An application must be submitted to the board on forms supplied by the board. The application must be complete in every detail before licensure may be granted and must be accompanied by a nonrefundable fee. As part of the application process, the supervising physician and physician assistant must specify clearly in detail those medical acts, tasks, or functions for which approval is being sought. The specific medical acts, tasks, or functions must be included in the scope of practice guidelines, and the scope of practice guidelines must accompany the application.

(B) When a board member or board designee or the administrative staff of the board has reviewed the entire application for completeness and correctness and has determined the eligibility or appropriateness of the application a temporary authorization may be issued immediately. At the next board meeting the application may be recommended for approval for a permanent license or other authorization consistent with this article. If a temporary authorization is not considered appropriate, the application must be reviewed by the committee and may be recommended to the board for approval as presented to or modified by the committee.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 3; 2013 Act No. 28, Section 3, eff May 21, 2013.

Effect of Amendment

The 2013 amendment, in subsection (A), substituted “before licensure may be granted” for “before it may be approved”.

**SECTION 40‑47‑945.** Conditions for granting permanent license.

(A) Except as otherwise provided in this article, an individual shall obtain a permanent license from the board before the individual may practice as a physician assistant. The board shall grant a permanent license as a physician assistant to an applicant who has:

(1) submitted a completed application on forms provided by the board;

(2) paid the nonrefundable application fees established in this article;

(3) successfully completed an educational program for physician assistants approved by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor organization;

(4) successfully completed the NCCPA certifying examination and provide documentation that the applicant possesses a current, active, NCCPA certificate;

(5) certified that the applicant is mentally and physically able to engage safely in practice as a physician assistant;

(6) no licensure, certificate, or registration as a physician assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant’s practice as a physician assistant;

(7) good moral character;

(8) submitted to the board other information the board considers necessary to evaluate the applicant’s qualifications;

(9) appeared before a board member or board designee with all original diplomas and certificates and demonstrated knowledge of the contents of this article. A temporary authorization to practice may be issued as provided in Section 40‑47‑940 pending completion of this requirement and subject to satisfactory interview as provided below; and

(10) successfully completed an examination administered by the committee on the statutes and regulations regarding physician assistant practice and supervision.

(B) Not later than ninety days from the date a temporary authorization is issued, each applicant shall appear before a board member or board designee and demonstrate knowledge of the contents of this article. Failure to appear within the prescribed time automatically results in the immediate invalidation of the authorization to practice pending compliance and further order of the board. If approved, a permanent license may be issued immediately. If not approved, the application must be reviewed by the committee and may be recommended to the board for approval as presented to or modified by the committee.

(C) The supervising physician of a limited licensee physically must be present on the premises at all times when the limited licensee is performing a task.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 4; 2013 Act No. 28, Section 4, eff May 21, 2013.

Effect of Amendment

The 2013 amendment, in subsection (A)(9), deleted “the applicant’s supervising physician and” before “all original diplomas and certificates”; in subsection (B), deleted “with the applicant’s supervising physician and scope of practice guidelines” following “board member or board designee”; and deleted the second sentence in subsection (C), relating to on‑the‑job training.

**SECTION 40‑47‑950.** Limited physician assistant license; conditions for issuance; duration; responsibilities of supervising physician.

(A) The board may issue a limited physician assistant license to an applicant who has:

(1) submitted a completed application on forms provided by the board;

(2) paid the nonrefundable application fees established by this regulation;

(3) successfully completed an educational program for physician assistants approved by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor organization;

(4) never previously failed two consecutive NCCPA certifying examinations and has registered for, or intends to register to take the next offering of, the NCCPA examination;

(5) certified that the applicant mentally and physically is able to engage safely in practice as a physician assistant;

(6) no licensure, certificate, or registration as a physician assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant’s practice as a physician assistant;

(7) good moral character;

(8) submitted to the board any other information the board considers necessary to evaluate the applicant’s qualifications;

(9) appeared before a board member or board designee with all original diplomas and certificates and demonstrated knowledge of the contents of this article; and

(10) successfully completed an examination administered by the committee on the statutes and regulations regarding physician assistant practice and supervision.

(B) A limited license is not renewable and is valid only until the results of a limited licensee’s two consecutive NCCPA certifying examinations are reported to the board. When a limited licensee has failed two consecutive NCCPA certifying examinations, or fails one exam and does not take the NCCPA certifying examination at the next opportunity or, after applying for a limited license, fails to register for the next offering of the examination, the limited license immediately is void and the applicant is no longer eligible to apply for further limited licensure.

(C) The supervising physician of a limited licensee physically must be present on the premises at all times when the limited licensee is performing a task.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 5; 2013 Act No. 28, Sections 5, 6, eff May 21, 2013.

Effect of Amendment

The 2013 amendment, in subsection (A)(9), deleted “the applicant’s supervising physician and” before “all original diplomas and certificates”; and in subsection (C), deleted the second sentence, relating to on‑the‑job training.

**SECTION 40‑47‑955.** Scope of physician assistant’s practice; physical presence requirements of supervising physician; practices in separate locations; granting of exceptions.

(A) The supervising physician is responsible for all aspects of the physician assistant’s practice. Supervision must be continuous but must not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where the services are rendered, except as otherwise required for limited licensees. The supervising physician shall identify the physician assistant’s scope of practice and determine the delegation of medical acts, tasks, or functions. Medical acts, tasks, or functions must be defined in written scope of practice guidelines which must be appropriate to the physician assistant’s ability and knowledge.

(B) Pursuant to scope of practice guidelines, a physician assistant may practice in a public place, a private place, or a facility where the supervising physician regularly sees patients, may make house calls, perform hospital duties, and perform any functions performed by the supervising physician if the physician assistant is also qualified to perform those functions.

(C) A physician assistant must have six months of clinical experience with the current supervising physician before being permitted to practice at a location off site from the supervising physician, except that a physician assistant who has at least two years continuous practice in the same specialty may practice at a location off site from the supervising physician after three months clinical experience with the supervising physician and upon request of the supervising physician. This three‑month requirement may be waived for experienced physician assistants and supervisors upon recommendation of the committee and approval by the board. The off‑site location may not be more than sixty miles of travel from the supervising physician or alternate supervising physician without written approval of the board. Notice of off‑site practice must be filed with the administrative staff of the board before off‑site practice may be authorized. The supervising physician or alternate must review, initial, and date the off‑site physician assistant’s charts periodically as provided in the written scope of practice guidelines, provided the supervising physician must review and verify the adequacy of clinical practice of ten percent of these charts monthly.

(D) A supervising physician may simultaneously supervise no more than three physician assistants providing clinical service at one time.

(E) Upon written request, and recommendation of the committee, the board may authorize exceptions to the requirements of this section.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 6; 2013 Act No. 28, Section 7, eff May 21, 2013.

Effect of Amendment

The 2013 amendment, in subsection (A), substituted “defined in written scope of practice guidelines” for “defined in approved written guidelines”; and rewrote subsections (B) through (D).

**SECTION 40‑47‑960.** Scope of practice guidelines; signature and filing requirements; contents.

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervisory physicians and the physician assistant. Copies of the guidelines must be on file at all practice sites. The guidelines shall include at a minimum the:

(1) name, license number, and practice addresses of all supervising physicians;

(2) name and practice address of the physician assistant;

(3) date the guidelines were developed and dates they were reviewed and amended;

(4) medical conditions for which therapies may be initiated, continued, or modified;

(5) treatments that may be initiated, continued, or modified;

(6) drug therapy, if any, that may be prescribed with drug‑specific classifications; and

(7) situations that require direct evaluation by or immediate referral to the physician, including Schedule II controlled substance prescription authorization as provided for in Section 40‑47‑965.

HISTORY: 2000 Act No. 359, Section 1; 2013 Act No. 28, Section 8, eff May 21, 2013.

Effect of Amendment

The 2013 amendment, in subsection (7), added the text at the end relating to Schedule II controlled substance prescriptions.

**SECTION 40‑47‑965.** Requirements for writing prescriptions for drugs, controlled substances, and medical devices.

(A) If the written scope of practice guidelines authorizes the physician’s assistant to prescribe drug therapy:

(1) prescriptions for authorized drugs and devices shall comply with all applicable state and federal laws;

(2) prescriptions must be limited to drugs and devices authorized by the supervising physician and set forth in the written scope of practice guidelines;

(3) prescriptions must be signed by the physician assistant and must bear the physician assistant’s identification number as assigned by the board and all prescribing numbers required by law. The preprinted prescription form shall include both the physician assistant’s and physician’s name, address, and phone number and shall comply with the provisions of Section 39‑24‑40;

(4) drugs or devices prescribed must be specifically documented in the patient record;

(5) the physician assistant may request, receive, and sign for professional samples of drugs authorized in the written scope of practice guidelines and may distribute professional samples to patients in compliance with appropriate federal and state regulations and the written scope of practice guidelines;

(6) the physician assistant may authorize prescriptions for an orally administered Schedule II controlled substance, as defined in the federal Controlled Substances Act, pursuant to the following requirements:

(a) the authorization to prescribe is expressly approved by the supervising physician as set forth in the physician assistant’s written scope of practice guidelines;

(b) the physician assistant has directly evaluated the patient;

(c) the authority to prescribe is limited to an initial prescription and must not exceed a seventy‑two hour supply;

(d) any subsequent prescription authorization must be in consultation with and upon patient examination and evaluation by the supervising physician, and must be documented in the patient’s chart; and

(e) any prescription for continuing drug therapy must include consultation with the supervising physician and must be documented in the patient’s chart;

(7) the physician assistant may authorize a medical order for parenteral administration of a Schedule II controlled substance, as defined in the federal Controlled Substances Act, pursuant to the following requirements:

(a) the authorization to write a medical order is expressly approved by the supervising physician as set forth in the physician assistant’s written scope of practice guidelines;

(b) the physician assistant is providing patient care in a hospital setting, including emergency and outpatient departments affiliated with the hospital;

(c) an initial patient examination and evaluation has been performed by the supervising physician, or his delegate physician, and has been documented in the patient’s chart; however, in a hospital emergency department, a physician assistant may authorize such a medical order if the supervising or delegate physician is unavailable due to clinical demands, but remains on the premises and is immediately available, and the supervising or delegate physician conducts the patient evaluation as soon as practicable and is documented in the patient’s chart;

(d) the physician assistant has directly evaluated the patient; and

(e) the written medical order may not exceed a one‑time administration within a twenty‑four hour period.

(B) When applying for controlled substance prescriptive authority, the applicant shall comply with the following requirements:

(1) the physician assistant shall provide evidence of completion of sixty contact hours of education in pharmacotherapeutics acceptable to the board before application;

(2) the physician assistant shall provide at least fifteen contact hours of education in controlled substances acceptable to the board;

(3) every two years, the physician assistant shall provide documentation of four continuing education hours related to approved procedures of prescribing and monitoring controlled substances listed in Schedules II, III, and IV of the schedules provided for in Sections 44‑53‑210, 44‑53‑230, and 44‑53‑250;

(4) the physician assistant must have a valid Drug Enforcement Administration (DEA) registration and prescribe in accordance with DEA rules; and

(5) the physician assistant and supervising physician must read and sign a document approved by the board describing the management of expanded controlled substances prescriptive authority for physician assistants in South Carolina which must be kept on file for review. Within the two‑year period, the physician assistant and the supervising physician periodically shall review this document and the physician assistant’s prescribing practices to ensure proper prescribing procedures are followed. This review must be documented in writing with a copy kept at each practice site.

(C) A physician assistant’s prescriptive authorization may be terminated by the board if the physician assistant:

(1) practices outside the written scope of practice guidelines;

(2) violates any state or federal law or regulation applicable to prescriptions; or

(3) violates a state or federal law applicable to physician assistants.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 7; 2013 Act No. 28, Section 9, eff May 21, 2013; 2017 Act No. 91 (H.3824), Section 7, eff May 19, 2017.

Effect of Amendment

The 2013 amendment, in subsection (A)(5), deleted “, except for controlled substances in Schedule II,” before “and may distribute professional samples”; added subsections (A)(6), (A)(7), and (B)(4); and redesignated former subsection (B)(4) as (B)(5).

2017 Act No. 91, Section 7, amended (B)(3), relating to adding requirements addressing the prescription and monitoring of certain controlled substances.

**SECTION 40‑47‑970.** Limitations on permissible medical act, task, or function physician assistant may perform.

A physician assistant may not:

(1) perform a medical act, task, or function which has not been listed and approved on the scope of practice guidelines;

(2) prescribe drugs, medications, or devices not specifically authorized by the supervising physician and documented in the written scope of practice guidelines;

(3) prescribe, under any circumstances, controlled substances in Schedule II except as authorized in Section 40‑47‑965;

(4) perform a medical act, task, or function that is outside the usual practice of the supervising physician.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 8; 2013 Act No. 28, Section 10, eff May 21, 2013.

Effect of Amendment

The 2013 amendment, in subsection (3), inserted “except as authorized in Section 40‑47‑965”.

**SECTIONS 40‑47‑975, 40‑47‑980.** Repealed by 2013 Act No. 28, Section 12, eff May 21, 2013.

Editor’s Note

Former Section 40‑47‑975 was titled On‑the‑job training requests and was derived from 2000 Act No. 359, Section 1.

Former Section 40‑47‑980 was titled Treatment of patients in chronic care and long‑term care facilities and was derived from 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 9.

**SECTION 40‑47‑985.** Inspection of office or facility employing physician assistant.

The board or a person designated by the board may make unscheduled inspections of any office or facility employing a physician assistant.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑990.** Identification as physician assistant; badge size and content.

A physician assistant must clearly identify himself or herself as a physician assistant to ensure that the physician assistant is not mistaken or misrepresented as a physician. A physician assistant shall wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the physician assistant’s name and the words “Physician Assistant”.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑995.** Termination of supervisory relationship; notice to board.

If the supervisory relationship between a physician assistant and the supervising physician is terminated for any reason, the physician assistant and the supervising physician shall inform the board immediately in writing of the termination, including the reasons for the termination. The approval of the practice setting terminates coterminous with the termination of the relationship, and practice shall cease until new scope of practice guidelines are submitted by a supervising physician and are approved by the board.

HISTORY: 2000 Act No. 359, Section 1; 2013 Act No. 28, Section 11, eff May 21, 2013.

Effect of Amendment

The 2013 amendment substituted “new scope of practice guidelines are submitted” for “a new application is submitted”.

**SECTION 40‑47‑1000.** Unlicensed person holding himself out as physician assistant; penalty; investigation; desist and refrain order; injunction; privileged communications; due process rights of respondent protected.

(A) It is unlawful for a person who is not licensed under this article to hold himself out as a physician assistant. A person who holds himself out as a physician assistant without being licensed under this article, during a period of suspension, or after his license has been revoked by the board is guilty of a misdemeanor and, upon conviction, must be fined not more than three hundred dollars or imprisoned for not more than ninety days, or both.

(B) For the purpose of any investigation or proceeding under the provisions of this article, the board or a person designated by the board may administer oaths and affirmations, subpoena witnesses, take testimony, and require the production of any documents or records which the board considers relevant to the inquiry.

(C) If the board has sufficient evidence that a person is violating a provision of this article, the board, in addition to all other remedies, may order the person to immediately desist and refrain from this conduct. The board may apply to an administrative law judge as provided under Article 5 of Chapter 23 of Title 1 for an injunction restraining the person from this conduct. An administrative law judge may issue a temporary injunction ex parte and upon notice and full hearing may issue any other order in the matter it considers proper. No bond may be required of the board by an administrative law judge as a condition to the issuance of any injunction or order contemplated by the provisions of this section.

(D) Investigations and disciplinary proceedings under this article must be conducted in accordance with the provisions of Article 1.

(E) No provision of this article may be construed as prohibiting the respondent or his legal counsel from exercising the respondent’s constitutional right of due process under the law or prohibiting the respondent from normal access to the charges and evidence filed against him as a part of due process under the law.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 10.

**SECTION 40‑47‑1005.** Misconduct mandating revocation or denial of license.

Misconduct constituting grounds for revocation, suspension, probation, reprimand, restrictions, or denial of a license must be found when a physician assistant:

(1) has knowingly allowed himself or herself to be misrepresented as a physician;

(2) has filed or has had filed on his or her behalf with the board any false, fraudulent, or forged statement or documents;

(3) has performed any work assignment, task, or other activity which is not on the physician assistant scope of practice guidelines;

(4) misuses alcohol or drugs to such a degree to render him or her unfit to practice as a physician assistant;

(5) has been convicted of a felony or a crime involving moral turpitude or drugs;

(6) has sustained any physical or mental disability which renders further practice dangerous to the public;

(7) has engaged in any dishonorable or unethical conduct that is likely to deceive or harm patients;

(8) has used or made any false or fraudulent statement in any document connected with practice or licensure as a physician assistant;

(9) has obtained or assisted another person in obtaining fees under dishonorable, false, or fraudulent circumstances;

(10) has violated or conspired with another person to violate any provision of this article; or

(11) otherwise demonstrates a lack of the ethical or professional competence required to act as a physician assistant.

HISTORY: 2000 Act No. 359, Section 1.

**SECTION 40‑47‑1010.** Renewal of license.

A license issued pursuant to this chapter may be renewed biennially or as otherwise provided by the board and department. A person who has not demonstrated continuing education, as required by this article, is not eligible for issuance or renewal of an authorization to practice.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 11.

**SECTION 40‑47‑1015.** Fees for licensure.

(A) Fees for physician assistant licensure are established as follows:

(1) initial licensing fee, not to exceed five hundred dollars;

(2) renewal of license fee, not to exceed one hundred and fifty dollars;

(3) late renewal fee, not to exceed the renewal fee doubled;

(4) reactivation application fee, not to exceed two hundred dollars;

(5) change in supervisor fee, not to exceed one hundred and fifty dollars;

(6) additional primary supervisor for dual employment fee, not to exceed one hundred and fifty dollars.

(B) Fees may be adjusted biennially pursuant to Section 40‑1‑50 to ensure that they are sufficient but not excessive to cover expenses including the total of the direct and indirect costs to the State for the operations of the committee.

HISTORY: 2000 Act No. 359, Section 1; 2006 Act No. 244, Section 12.

**SECTION 40‑47‑1020.** Third party reimbursement to physician assistant.

Nothing in this article may be construed to require third party reimbursement directly to a physician assistant for services rendered.

HISTORY: 2000 Act No. 359, Section 1.

ARTICLE 9

South Carolina Anesthesiologist’s Assistants Practice Act

**SECTION 40‑47‑1205.** Short title.

This article may be cited as the “South Carolina Anesthesiologist’s Assistants Practice Act”.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1210.** Definitions.

As used in this article:

(1) “Anesthesiologist” means a physician who has successfully completed an approved anesthesiology training program including, but not limited to, a program approved by the Accreditation Committee on Graduate Medical Education, American Osteopathic Association, or its equivalent or successor.

(2) “Anesthesiologist’s assistant” means an allied health graduate of an accredited anesthesiologist’s assistant program who is currently certified by the National Commission for Certification of Anesthesiologist’s Assistants and who works under the direct supervision of an anesthesiologist who is immediately available in the operating suite and is physically present during the most demanding portions of the anesthetic including, but not limited to, induction and emergence.

(3) “Board” means the Board of Medical Examiners of South Carolina.

(4) “Committee” means the Anesthesiologist’s Assistant Committee as established by this article as an advisory committee responsible to the board.

(5) “NCCAA” means the National Commission on Certification of Anesthesiologist’s Assistants, Inc., the agency recognized to examine and evaluate the education of anesthesiologist’s assistants, or its successor organization as recognized by the board.

(6) “Sponsoring anesthesiologist” means the physician specialist in anesthesiology who signs the anesthesiologist’s assistant’s application for licensure. The sponsoring anesthesiologist must be a South Carolina licensed physician currently possessing an active, unrestricted license to practice medicine in this State who practices in the medical specialty of anesthesiology, approved by the Accreditation Committee on Graduate Medical Education, or its equivalent or successor. The sponsoring anesthesiologist also may be the supervising anesthesiologist.

(7) “Supervising anesthesiologist” means a South Carolina licensed physician currently possessing an active, unrestricted license to practice medicine in South Carolina who practices in the medical specialty of anesthesiology and has successfully completed a residency in anesthesiology, approved by the Accreditation Committee on Graduate Medical Education, American Osteopathic Association, or its equivalent or successor.

(8) “Supervision” means medically directing and accepting responsibility for the anesthesia services rendered by an anesthesiologist’s assistant in a manner approved by the board. The supervising anesthesiologist must be in the hospital and in the anesthetizing or operative area such that he can be immediately available to participate directly in the care of the patient with whom the anesthesiologist’s assistant and the anesthesiologist are jointly involved.

HISTORY: 2001 Act No. 57, Section 1; 2006 Act No. 321, Sections 1, 7.

**SECTION 40‑47‑1215.** Application of this article.

This article does not apply to a person who is employed as an anesthesiologist’s assistant by the United States Government, where such services are provided solely under the direction or control of the United States Government.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1220.** Department of Labor staff.

The Director of the Department of Labor, Licensing and Regulation may employ additional staff as necessary for the performance of the department’s duties under this article.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1225.** Anesthesiologist’s Assistant Committee.

(A) There is created the Anesthesiologist’s Assistant Committee as an advisory committee to the Board of Medical Examiners which consists of nine members to be appointed by the board. Three of the members must be licensed anesthesiologist’s assistants with a minimum of three years of patient care experience. Two members must be consumers and three members must be physicians who are licensed to practice in this State. Of the three physician members, at least one must regularly employ an anesthesiologist’s assistant. One member of the Board of Medical Examiners shall serve on the committee ex officio, with full rights to participate and vote. All organizations, groups, or interested individuals may submit recommendations to the board of at least two individuals for each position to be filled on the committee.

(B) The members shall serve for terms of four years and until their successors are appointed and qualify, except the initial term of two anesthesiologist’s assistants, the consumer member, and one physician are for two years. Vacancies must be filled in the manner of the original appointment for the unexpired portion of the term. The board, after notice and opportunity for hearing, may remove any member of the committee for negligence, neglect of duty, incompetence, revocation or suspension of license, or other dishonorable conduct. Members of the committee shall receive mileage, subsistence, and per diem as provided by law for members of state boards, commissions, and committees for each meeting attended. No member may serve more than two full four‑year terms consecutively but may be eligible for reappointment four years from the date the last full four‑year term expired.

(C) The committee shall meet at least two times yearly and at other times as may be necessary. A majority of the members currently serving, not less than two of whom must be physician members, constitutes a quorum. At its initial meeting, and at the beginning of each year thereafter, the committee shall elect from its membership a chairman, vice‑chairman, and secretary to serve for a term of one year.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1230.** Duties of Anesthesiologist’s Assistant Committee.

(A) The committee shall evaluate the qualifications for licensure and make recommendations to the board.

(B) The committee:

(1) may recommend regulations to the board relating to professional conduct to carry out the provisions of this article including, but not limited to, professional certification and the establishment of ethical standards of practice for persons holding a license to practice as an anesthesiologist’s assistant in this State;

(2) shall conduct hearings and keep records and minutes necessary to carry out its functions;

(3) shall provide notice of all hearings authorized under this article pursuant to the Administrative Procedures Act;

(4) shall determine the additional qualifications and make recommendations regarding the issuance of licenses to qualified anesthesiologist’s assistants; however, these recommendations may not be less stringent than the requirements for national licensure;

(5) shall recommend to the board whether to issue or renew licenses under those conditions prescribed in this article;

(6) may recommend requirements to the board for continuing professional education of anesthesiologist’s assistants;

(7) shall keep a record of its proceedings and a register of all licensees, including names and last known places of employment and residence. The board shall annually compile and make available a list of anesthesiologist’s assistants authorized to practice in this State. An interested person may obtain a copy of this list upon application to the board and payment of an amount sufficient to cover the cost of printing and mailing;

(8) shall report annually to the board on duties performed, actions taken, and recommendations;

(9) shall hear disciplinary cases and recommend findings of fact, conclusions of law, and sanctions to the board. The board shall conduct a final order hearing at which it shall make a final decision;

(10) shall perform such duties and tasks as may be delegated to the committee by the board.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1235.** Functions and duties of anesthesiologist’s assistants.

Anesthesiologist’s assistants may perform medical tasks and services within the framework of a written practice protocol developed for the anesthesiologist’s assistant. Within this practice protocol the anesthesiologist’s assistant, under the direction of the anesthesiologist may engage in these functions and duties:

(1) obtaining relevant preoperative health history by record or chart review and by direct contact with the patient in the preoperative period;

(2) presenting preoperative health information to the supervising anesthesiologist for the collaborative formulation of an anesthetic plan;

(3) performing initial acute cardio‑pulmonary resuscitation in life‑threatening situations as directed by a physician;

(4) initiating medically directed multi‑parameter monitoring before anesthesia and in other acute care settings. Modalities that may be used include, but are not limited to, American Society of Anesthesiologists Standard Monitors, arterial and venous catheters, or any other current medically accepted modality. The anesthesiologist’s assistant may obtain data from monitors or devices that are indicated and may initiate medically directed therapy. The anesthesiologist’s assistant may administer drugs used in anesthetic practice by written protocol or as directed by the supervising anesthesiologist;

(5) using current advanced treatment modalities to effect the prescribed anesthetic plan during the procedure. These advanced treatment modalities may include, but are not limited to, basic and advanced airway interventions, including intubation of the trachea; administering intermittent vasoactive drugs, starting and adjusting vasoactive infusions, administering anesthetic, adjuvant, and accessory drugs; administering blood and blood products; and any other treatment modalities prescribed by the medically directing anesthesiologist and within the training and expertise of the anesthesiologist’s assistant;

(6) supporting the patient upon emergence and recovery from an anesthetic by airway intervention or ventilatory support and administering any supportive medication and fluids;

(7) participating in administrative, educational, and research activities as appropriate.

An anesthesiologist’s assistant may not present himself or herself as an anesthesiologist, any other type of physician, or a nurse anesthetist. The required nomenclature is: “Anesthesiologist’s Assistant”.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1240.** Licensure of anesthesiologist’s assistants.

Except as otherwise provided in this article, an individual must obtain a license in accordance with this article before the individual may practice as an anesthesiologist’s assistant. The board shall grant a license as an anesthesiologist’s assistant to an applicant who has:

(1) submitted a completed application on forms provided by the board;

(2) paid the nonrefundable application fees established in this article;

(3) certified that he or she is mentally and physically able to engage safely in practice as an anesthesiologist’s assistant;

(4) submitted evidence to the board that the applicant has obtained a baccalaureate or higher degree from an institution of higher education accredited by an organization recognized by the Commission on Higher Education. This degree program must have included courses in these areas of study:

(a) general biology;

(b) general chemistry;

(c) organic chemistry;

(d) physics;

(e) calculus; and

(5) submitted evidence to the board that the applicant has obtained a graduate‑level degree from a program accredited by the Commission on Accreditation of Allied Health Education Programs, or any of the commission’s successor organizations, and the graduate degree program must have included the following:

(a) courses in the basic sciences of anesthesia, including general pharmacology, physiology, pathophysiology, anatomy, and biochemistry, and these courses must be presented as a continuum of didactic courses designed to teach students the foundations of human biological existence on which clinical correlations to anesthesia practice are based;

(b) pharmacology for the anesthetic sciences which must include instruction in the anesthetic principles of pharmacology, pharmacodynamics, pharmacokinetics, uptake and distribution, intravenous anesthetics and narcotics, and volatile anesthetics;

(c) physics in anesthesia; and

(d) fundamentals of anesthetic sciences, presented as a continuum of courses covering a series of topics in basic medical sciences with special emphasis on the effects of anesthetics on normal physiology and pathophysiology;

(6) submitted evidence satisfactory to the board that the applicant holds current certification from the National Commission for Certification of Anesthesiologist’s Assistants and that the requirements for receiving the certification included passage of an examination to determine the individual’s competence to practice as an anesthesiologist’s assistant;

(7) no licensure, certificate, or registration as an anesthesiologist’s assistant under current discipline, revocation, suspension, probation, or investigation for cause resulting from the applicant’s practice as an anesthesiologist’s assistant in any jurisdiction;

(8) appeared before a board member or board designee with his or her sponsoring anesthesiologist, presenting all original diplomas and certificates and demonstrated knowledge of the contents of this article; and

(9) submitted to the board any other information the board considers necessary to evaluate the applicant’s qualifications.

HISTORY: 2001 Act No. 57, Section 1; 2006 Act No. 321, Section 2.

**SECTION 40‑47‑1245.** Sponsoring anesthesiologist; protocol delineating services provided by anesthesiologist’s assistant.

An anesthesiologist who agrees to act as the sponsoring anesthesiologist of an anesthesiologist’s assistant shall adopt a written practice protocol that delineates the service that the anesthesiologist’s assistant is authorized to provide and the manner in which the anesthesiologist will supervise the anesthesiologist’s assistant. The anesthesiologist shall base the provisions of the protocol on consideration of relevant quality assurance standards, including being present at the most important times of the case and timely review of the patient’s anesthesia record at appropriate times during the course of the anesthetic procedure. The protocol must be reviewed by the anesthesiologist at least once a year.

HISTORY: 2001 Act No. 57, Section 1; 2006 Act No. 321, Section 3.

**SECTION 40‑47‑1250.** Supervision of anesthesiologist’s assistants.

An anesthesiologist’s assistant shall practice only under the supervision of a physician who is actively and directly engaged in the clinical practice of medicine and meets the definition of being a supervising anesthesiologist. An anesthesiologist may not supervise more than two anesthesiologist’s assistants at any one time.

HISTORY: 2001 Act No. 57, Section 1; 2006 Act No. 321, Section 4.

**SECTION 40‑47‑1255.** Anesthesiologist’s assistants to practice pursuant to written protocol.

An anesthesiologist’s assistant practicing at all sites shall practice pursuant to written scope of practice protocols signed by all supervising anesthesiologists and the anesthesiologist’s assistant. Copies of the protocols must be on file at all practice sites. The protocols shall include at a minimum the:

(1) name, license number, and practice addresses of the sponsoring anesthesiologist;

(2) name and practice address of the anesthesiologist’s assistant;

(3) date the protocol was developed and dates it was reviewed or amended;

(4) situations that require direct evaluation by or immediate referral to the anesthesiologist.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1260.** Limitations on practice of anesthesiologist’s assistants.

An anesthesiologist’s assistant may not:

(1) perform a task which has not been listed and approved on the scope of the practice protocol currently on file with the board;

(2) prescribe drugs, medications, or devices of any kind.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1265.** Inspections.

The board or a person designated by the board may make unscheduled inspections of any office or facility employing an anesthesiologist’s assistant.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1270.** Identification of anesthesiologist’s assistants.

An anesthesiologist’s assistant must clearly identify himself or herself as an anesthesiologist’s assistant to ensure that the anesthesiologist’s assistant is not mistaken or misrepresented as a physician. An anesthesiologist’s assistant shall wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the anesthesiologist’s assistant’s name and the words “Anesthesiologist’s Assistant”. Patients in facilities utilizing anesthesiologist’s assistants must be informed when an anesthesiologist’s assistant will be involved in their anesthesia care.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1275.** Termination of sponsoring relationship between anesthesiologist and assistant.

If the sponsoring relationship between an anesthesiologist’s assistant and the sponsoring anesthesiologist is terminated for any reason, both the anesthesiologist’s assistant and the sponsoring anesthesiologist shall inform the board immediately in writing of the termination, including the reasons for the termination. The approval of the practice setting terminates coterminous with the termination of the relationship, and practice shall cease until a new application is submitted by a sponsoring anesthesiologist and is approved by the board.

HISTORY: 2001 Act No. 57, Section 1; 2006 Act No. 321, Section 5.

**SECTION 40‑47‑1280.** Violations of this article.

(A) It is unlawful for a person who is not licensed under this article to hold himself out as an anesthesiologist’s assistant. A person who holds himself out as an anesthesiologist’s assistant without being licensed under this article, during a period of suspension, or after his license has been revoked by the board is guilty of a misdemeanor and, upon conviction, must be fined not more than three hundred dollars or imprisoned for not more than ninety days, or both.

(B) For the purpose of any investigation or proceeding under this article, the board or a person designated by the board may administer oaths and affirmations, subpoena witnesses, take testimony, and require the production of any documents or records which the board considers relevant to the inquiry.

(C) If the board has sufficient evidence that a person is violating a provision of this article, the board, in addition to all other remedies, may order the person to immediately desist and refrain from this conduct. The board may apply to an administrative law judge as provided under Article 5 of Chapter 23 of Title 1 for an injunction restraining the person from this conduct. An administrative law judge may issue a temporary injunction ex parte and upon notice and full hearing may issue any other order in the matter it considers proper. No bond may be required of the board by an administrative law judge as a condition to the issuance of any injunction or order contemplated by the provisions of this section.

(D) No provision of this article may be construed as prohibiting the respondent or his legal counsel from exercising the respondent’s constitutional right of due process under the law or prohibiting the respondent from normal access to the charges and evidence filed against him as a part of due process under the law.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1285.** Grounds for disciplinary action.

Misconduct constituting grounds for revocation, suspension, probation, reprimand, restrictions, or denial of a license must be found when an anesthesiologist’s assistant:

(1) has knowingly allowed himself or herself to be misrepresented as a physician;

(2) has filed or has had filed on his or her behalf with the board any false, fraudulent, or forged statement or documents;

(3) has performed any work assignment, task, or other activity which is not on the anesthesiologist’s assistant’s written practice protocol;

(4) misuses alcohol or drugs to such a degree to render him or her unfit to practice as an anesthesiologist’s assistant;

(5) has been convicted of a felony or a crime involving moral turpitude or drugs;

(6) has sustained any physical or mental disability which renders further practice dangerous to the public;

(7) has engaged in any dishonorable or unethical conduct that is likely to deceive or harm patients;

(8) has used or made any false or fraudulent statement in any document connected with practice or licensure as an anesthesiologist’s assistant;

(9) has obtained or assisted another person in obtaining fees under dishonorable, false, or fraudulent circumstances;

(10) has violated or conspired with another person to violate any provision of this article; or

(11) otherwise demonstrates a competence required to act as an anesthesiologist’s assistant.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1290.** License renewal.

An anesthesiologist’s assistant’s license must be renewed on or before the first of January of each licensure period. Upon payment of the nonrefundable renewal fee provided for in Section 40‑47‑1295 and submission of documentation that the anesthesiologist’s assistant certificate issued by the National Commission for Certification of Anesthesiologist’s Assistants, or its successor, is active and current, the board shall renew the anesthesiologist’s assistant’s license.

HISTORY: 2001 Act No. 57, Section 1.

**SECTION 40‑47‑1295.** Maximum fees.

(A) Fees for anesthesiologist’s assistant licensure are established as follows:

(1) initial licensing fee, not to exceed one thousand dollars;

(2) renewal of license fee, not to exceed three hundred dollars;

(3) late renewal fee, not to exceed the renewal fee doubled;

(4) reactivation application fee, not to exceed three hundred dollars;

(5) change in supervisor sponsor fee, not to exceed three hundred dollars.

(B) Fees may be adjusted biennially in accordance with Section 40‑1‑50 to ensure that they are sufficient but not excessive to cover expenses including the total of the direct and indirect costs to the State for the operations of the committee.

HISTORY: 2001 Act No. 57, Section 1; 2006 Act No. 321, Section 6.

**SECTION 40‑47‑1300.** Third party reimbursement.

Nothing in this article may be construed to require third party reimbursement directly to an anesthesiologist’s assistant for services rendered.

HISTORY: 2001 Act No. 57, Section 1.

ARTICLE 10

South Carolina Registered Cardiovascular Invasive Specialist Act

Editor’s Note

2005 Act No. 10, Section 6.A, provides:

“The General Assembly recognizes that the practice of cardiovascular invasive specialists is potentially harmful to the public in that the public does not have an adequate method to verify the qualifications of those persons who hold themselves out as qualified to practice.”

**SECTION 40‑47‑1510.** Citation of article.

This article may be cited as the “South Carolina Registered Cardiovascular Invasive Specialist Act”.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1520.** Definitions.

As used in this article:

(1) “Cardiologist” means a physician who has successfully completed an approved cardiology training program including, but not limited to, a program approved by the Accreditation Committee on Graduate Medical Education, or its equivalent or successor.

(2) “Cardiovascular Invasive Specialist” means a cardiovascular invasive specialist who is currently registered by Cardiovascular Credentialing International, has graduated from an accredited program of Cardiovascular Invasive Technology and who working under the direct supervision of a cardiologist performs procedures on patients resulting in accurate diagnosis and/or optimal treatment of congenital or acquired heart disease.

(3) “Supervising cardiologist” means a South Carolina licensed physician currently possessing an active, unrestricted license to practice medicine in South Carolina who practices in the medical specialty of cardiology and has successfully completed a residency in cardiology, approved by the Accreditation Committee on Graduate Medical Education, or its equivalent or successor.

(4) “Supervision” means medically directing and accepting responsibility for the cardiac services rendered by a registered cardiovascular invasive specialist in a manner provided for in law and the adopted protocol of the licensed facility. The supervising cardiologist must be in the facility and in the operative area such that he can be immediately available to participate directly in the care of the patient with whom the invasive cardiovascular specialist and the cardiologist are jointly involved.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1530.** Registration requirement.

A person may not wilfully practice or offer to practice as a cardiovascular invasive specialist unless that person is registered by the department. A person who uses the title cardiovascular specialist in any advertisement, business card or letterhead, or billing document or who makes another verbal or written communication indicating that the person is a cardiovascular specialist or who acquiesces in that representation violates this section.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1540.** Application for registration.

To be registered by the department as a cardiovascular invasive specialist, a person must:

(1) apply in writing to the department on a form available from the department;

(2) successfully complete an approved cardiology training program including, but not limited to, a program approved by the Accreditation Committee of Graduate Medical Education, or its equivalent or successor approved by the South Carolina Board of Medical Examiners;

(3) provide satisfactory evidence of current registration with Cardiovascular Credentialing International;

(4) provide satisfactory evidence that the applicant’s practice protocol is in place, signed by each supervising cardiologist and by an appropriate representative of each licensed facility where practice is anticipated;

(5) pay a fee established by the department.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1550.** Renewal; lapse of registration.

(A) Registration by the department as a cardiovascular invasive specialist must be renewed every two years. To renew a registration, a person shall:

(1) submit a complete application in writing;

(2) demonstrate continued competency including current registration with Cardiovascular Credentialing International and other requirements as provided by this article or regulation;

(3) pay a fee established by the department.

(B) A registration by the department as a cardiovascular invasive specialist automatically lapses if the registered person fails to make a timely and complete application for renewal or if the registered person fails to maintain current registration with Cardiovascular Credentialing International or another organization approved by the board.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1560.** Authorized tasks and services; supervision by cardiologist; written protocols.

(A) Cardiovascular invasive specialists may perform medical tasks and services within the framework of a facility’s written practice protocol developed for the cardiovascular invasive specialist. Within this practice protocol the registered cardiovascular invasive specialist, under the supervision of a cardiologist may engage in these functions and duties:

(1) perform baseline patient assessment;

(2) evaluate patient response to diagnostic or interventional maneuvers and medications during cardiac catheterization laboratory procedures;

(3) provide patient care and drug administration commonly used in the cardiac catheterization laboratory under the direction of a qualified physician and subject to the oversight of the facility;

(4) act as the first assistant during diagnostic and therapeutic catheterization procedures; and

(5) assist in advanced cardiac life support procedures.

(B) A cardiovascular invasive specialist shall practice only under the supervision of a physician who is actively and directly engaged in the clinical practice of medicine as a cardiologist.

(C) A cardiovascular invasive specialist practicing at all sites shall practice pursuant to written scope of the facility’s practice protocols signed by all supervising cardiologists and the cardiovascular invasive specialists. Copies of the protocols must be on file at all practice sites. The protocols shall include at a minimum the:

(1) name, license number, and practice addresses of the supervising cardiologists;

(2) name and practice address of the cardiovascular invasive specialists;

(3) date the protocol was developed and dates it was reviewed or amended;

(4) situations that require direct evaluation by or immediate referral to a cardiologist.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1570.** Administration of registration program; registry maintenance and availability; promulgation of regulations.

(A) The department is responsible for all administrative activities of the registration program. The department shall employ and supervise personnel necessary to effectuate the provisions of this article and shall establish fees sufficient, but not excessive, to cover expenses including direct and indirect costs to the State for the operations of this registration program. Fees must be adjusted as required by Title 40, Chapter 1.

(B) The department shall maintain a registry of all applications for registration and of all persons holding registration and shall make the roster of registered cardiovascular invasive specialists available on the department web site.

(C) The Board of Medical Examiners may promulgate regulations as necessary to effectuate this chapter.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1580.** Investigations of unfitness to practice or unauthorized practice.

If the department has reason to believe that a person registered pursuant to this article has become unfit to practice as a registered cardiovascular invasive specialist or if a complaint is filed with the department charging the registered person with the violation of a provision of this article or if a complaint is filed with the department alleging that an unregistered person is fraudulently holding himself or herself out as registered, the department shall institute an investigation in accordance with the procedures of Chapter 40, Title 1 and this article.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1590.** Hearing before Administrative Law Court; grounds for revocation, suspension, or other discipline.

(A) If, after investigation, it appears that the person registered pursuant to this article has become unfit to practice or has violated this article, the department shall file a petition with the Administrative Law Court, stating the facts and the particular statutes and regulations at issue.

(B) The Administrative Law Court, after opportunity for hearing, may order that the registration be revoked, suspended, or otherwise disciplined in accordance with Section 40‑1‑120 on the grounds that the registrant:

(1) used a false, fraudulent, or forged statement or document or committed a fraudulent, deceitful, or dishonest act or omitted a material fact in obtaining registration pursuant to this article;

(2) has had an authorization to practice a regulated profession or occupation in another state or jurisdiction canceled, revoked, or suspended, or has otherwise been disciplined by another jurisdiction;

(3) has lost or let lapse an underlying credential that served as the basis of registration;

(4) has intentionally used a false or fraudulent statement in a document connected with the practice of a registered cardiovascular invasive specialist;

(5) has obtained fees or assisted in obtaining fees under fraudulent circumstances; or

(6) has sustained a physical or mental disability or uses alcohol or drugs to such a degree as to render further practice as a registered cardiovascular invasive specialist dangerous to the public.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1600.** Proscribed activities; identification badges and notification of involvement in cardiac care.

(A) A cardiovascular invasive specialist may not:

(1) perform a task which has not been listed and approved on the scope of the practice protocol currently on file with the facility;

(2) prescribe drugs, medications, or devices of any kind.

(B) A cardiovascular invasive specialist must clearly identify himself or herself to ensure that the cardiovascular invasive specialist is not mistaken or misrepresented as a physician. A cardiovascular invasive specialist must wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the cardiovascular invasive specialist’s name and the words “Registered Cardiovascular Invasive Specialist”. Patients in facilities utilizing cardiovascular invasive specialists must be informed when a cardiovascular invasive specialist will be involved in their cardiac care.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1610.** Injunctions; fines; actions by unregistered persons.

(A) The Administrative Law Court, after opportunity for hearing, may order injunctive relief against a person who, without possessing a valid certificate pursuant to this article, uses the title or term registered cardiovascular invasive specialist. For each violation the administrative law judge may impose a fine of no more than ten thousand dollars.

(B) A person who is not registered as required by this article may not bring an action either at law or in equity to enforce the provisions of a contract for providing services as a registered cardiovascular invasive specialist.

HISTORY: 2005 Act No. 10, Section 6.B.

**SECTION 40‑47‑1620.** Promulgation of regulations.

The Department of Labor, Licensing and Regulation shall promulgate regulations necessary to ensure implementation or the provisions of this article.

HISTORY: 2005 Act No. 10, Section 6.B.