



## 2019-2021 RENEWAL APPLICATION FOR PHYSICIANS

### Renewal Instructions/Requirements:

- **ALL 40 CME hours must be completed before submitting your renewal [40 total = 30 specialty, 10 may be non-specialty, 2 must be in prescribing and monitoring of controlled substances].**
- Mail completed application and renewal fee in the form of a check or money order (no cash) in the amount of \$155.00 made payable to the S.C. Board of Medical Examiners to the address listed above. (All fees are non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.)
- Applications must be postmarked on or before June 30, 2019.
- After June 30, 2019, licenses will lapse and be subject to a \$100 per month late fee.
- "SC Code 40-47-41(C) A licensee shall notify the Board in writing within fifteen business days of any change or residential address, office address, or office telephone number." Failure to maintain a current address could result in important correspondence not reaching you.

SC License No.: \_\_\_\_\_

To find your Congressional District: <http://www.scstatehouse.gov/legislatorssearch.php>

### LICENSEE INFORMATION

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Since you were licensed, have you legally changed your name?  Yes  No Maiden Name: \_\_\_\_\_

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ District: \_\_\_\_\_  
Congressional District (SC Residents Only)

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(If different than above)

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email: \_\_\_\_\_

**Business Name (Primary Place of Practice):** \_\_\_\_\_

Check here if your position at your primary place of practice is best described as "Hospitalist"

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone No.: \_\_\_\_\_ Business Fax No.: \_\_\_\_\_

Business Email: \_\_\_\_\_ Hours/week: \_\_\_\_\_

**Business Name (Secondary Place of Practice):** \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone No.: \_\_\_\_\_ Business Fax No.: \_\_\_\_\_

Business Email: \_\_\_\_\_ Hours/week: \_\_\_\_\_

Are you a resident of SC?  Yes  No  
 Do you have an active or inactive license in another state?  Yes  No  
 Are you currently in a residency training or fellowship program?  Yes  No

**Specify training program:**

Do you plan to be in the military during the coming year?  Yes  No

United States:  Air Force  Army  Coast Guard  Marine Corps  Navy

**Activity Status:**

**Check only one**

01 Currently practicing profession  02 Not currently practicing profession  08 Retired  18 Out of State

Do you use telemedicine to deliver services to patients located in South Carolina?  Yes  No

**Primary Practice Setting (Where patients are seen):**

**Answer on the lines below, using the following options:**

**Primary Place of Practice:** \_\_\_\_\_

**Secondary Place of Practice:** \_\_\_\_\_

- |                                 |                                   |                                |
|---------------------------------|-----------------------------------|--------------------------------|
| 44 Admin/Regulatory Hlth Agency | 50 Business Establishment         | 20 Com Hlth Ctr/Rural Hlth Cln |
| 21 Fed Military Hlth Facility   | 22 Fed Non-Military Hlth Facility | 27 Free-Standing Amb Surg Ctr  |
| 13 Free-Standing Clinic         | 29 Free-Standing ER/Urgent Care   | 11 Hosp, Non-Fed General       |
| 23 Hosp, Non-Fed Psy            | 24 Hospital, Non-Fed Rehab        | 14 Outpat Mental Hlth Cline    |
| 15 Private Office               | 31 Univ/College of Med            | 71 Other specify: _____        |

**Form of Practice (Source of Income):**

**Primary Place of Practice Only – check only one**

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

Is your Primary Place of Practice owned by a hospital or health system?  Yes  No

**Hours Per Week:**

**Enter the approx. hours per week spent in practice across all locations**

**Total Hours:** \_\_\_\_\_

- |                               |                         |
|-------------------------------|-------------------------|
| • Patent Care Hours: _____    | • Research Hours: _____ |
| • Administration Hours: _____ | • Training Hours: _____ |
| • Teaching Hours: _____       | • Other Hours: _____    |

**Hours Per Week Spent In Specialties:**

**Should equal to Total Hours listed above (enter the approx. total hours per week in all specialties, across all practice locations)**

- |                              |                                     |
|------------------------------|-------------------------------------|
| • Primary Specialty: _____   | Hours in Primary Specialty: _____   |
| • Secondary Specialty: _____ | Hours in Secondary Specialty: _____ |
| • Third Specialty: _____     | Hours in Third Specialty: _____     |

**List all South Carolina hospital affiliations you presently have:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## CONTINUING EDUCATION

**Note: DO NOT SUBMIT continuing education certificates. The Board will not maintain copies. A random audit will be conducted at the end of the renewal period requiring proof of CME documentation.**

A list of approved Continuing Education Programs is available at [www.llr.sc.gov/POL/Medical/](http://www.llr.sc.gov/POL/Medical/)

Have you documented evidence of continuing education earned since July 1, 2017? **(Licensees who are in their first renewal cycle after receiving their initial permanent license are not required to report continuing education for this renewal only. If this applies to you, please check yes.)**

Yes  No

Have you documented evidence of completion of two (2) Category 1 CME hours **[date range for completion 7/1/17 – 6/30/19]** in approved procedures of prescribing and monitoring controlled substances? **(Licensees who are in their first renewal cycle after receiving their initial permanent license are not required to report continuing education for this renewal only. If this applies to you, please check yes.)**

Yes  No

If you are willing for your name to be added to a list of volunteer Physicians who may be called upon in the event of a public health emergency situation, please check this box:

## PERSONAL HISTORY QUESTIONS

If you answer Yes to any of the below questions, please attach a detailed written explanation along with any supporting documentation.

1. Since your last renewal (or if this is your first renewal since your initial license application), has any Order or other disciplinary action been rendered against you by any governmental professional licensing body (other than SC Board of Medical Examiners)?  Yes  No
2. Since your last renewal (or if this is your first renewal since your initial license application), have any hospital privileges or other professional privileges of any kind been revoked, suspended, restricted, denied, voluntarily surrendered or relinquished? (Include the relinquishment of privileges while under investigation or pending action for any reason. Do not include the relinquishment of privileges as a result of a personal decision.)  Yes  No
3. Since your last renewal (or if this is your first renewal since your initial license application), have you experienced any disease or conditions, physical, mental or emotional (i.e., bipolar disease, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice? (If you have voluntarily enrolled in Recovering Professionals Program (RPP) and have remained in full compliance, you may answer “No” with respect to any condition involving abuse of alcohol or drugs.)  Yes  No
4. Since your last renewal (or if this is your first renewal since your initial license application), have you been convicted, pled guilty or nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude?  Yes  No
5. Since your last renewal (or if this is your first renewal since your initial license application), have you voluntarily restricted or curtailed your practice other than for retirement, family leave or vacation?  Yes  No
6. Since your last renewal (or if this is your first renewal since your initial license application), have you changed your specialty?  Yes  No
7. Since your last renewal (or if this is your first renewal since your initial license application), has there been any change in the status of your lawful presence in the United States?  Yes  No

**ATTESTATION**

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina licensure.

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

**PRIVACY NOTICE**

South Carolina law requires the agency to collect personal information which is only disseminated as required by law. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on your renewal application and other documents on file may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical purposes.