



South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
 Synergy Business Park, Kingstree Building
 110 Centerview Drive, Suite 306
 Post Office Box 12517
 Columbia, SC 29211
 (803) 896-4501

**APPLICATION FOR A LICENSE TO PRACTICE AS
 A PHYSICIAN ASSISTANT**

Complete all sections of this application by providing all of the requested information. You must notify the Board in writing within fifteen (15) business days of any address changes after you file this application in order to receive information from the Board. This application form is a public document obtainable under the Freedom of Information Act.

PART I: Applicant Identifying Information					
1. Last Name	2. First Name	3. Middle Name	4. Suffix (Jr., III)		
5. Title Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>		6. Maiden Name			
8. Mailing Address (Street or PO Box, City, State, Zip)					
9. Home Address (Street, City, State, Zip – not PO Box)					9a. Home Congressional District
9b. Home Phone		9c. Home Fax		9d. Home Email	
10. Business Name		10a. Business Address (Street, City, State, Zip – not PO Box)			
10b. Business Phone		10c. Business Fax		10d. Business Email	
11. Place of Birth (List City & State or Country)	12. Date of Birth MM/DD/YYYY	13. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Race (For Statistical Purposes Only) <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic/Spanish Origin <input type="checkbox"/> American Indian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Other		
PART II: Education Information					
SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
Professional Education					
List in chronological order from date of graduation to the present <u>all</u> professional education. Do not include continuing education coursework, apprenticeship, intern, residency, vocational training practical or clinical training.					
INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM	DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
				Y <input type="checkbox"/> N <input type="checkbox"/>	
				Y <input type="checkbox"/> N <input type="checkbox"/>	
				Y <input type="checkbox"/> N <input type="checkbox"/>	
				Y <input type="checkbox"/> N <input type="checkbox"/>	

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

Was your education interrupted other than for vacation periods? If yes, attach a written explanation.	YES <input type="checkbox"/> NO <input type="checkbox"/>
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Branch of military service _____ date of service _____
 type of discharge (attach a copy) _____

NCCPA Certificate Number _____ Expiration date _____
Attach a copy)

PART III: Record of Licensure

Complete the requested information below if you have ever been licensed to practice in any profession or occupation. You must identify the method by which you obtained your license(s) and include jurisdiction both within and outside the United States current or inactive. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

Jurisdiction	Credential Type (MD or DO)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date issued
State of Original (Initial) Licensure:				

List Other Jurisdictions of Licensure:

PART IV: Employment History

List all related employment chronologically, most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable. Photocopy this page and attach if additional space is required.

1. Company Name			Company Address (Street, City, State, Zip)		
Job Title			Type of Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Date of Employment From: _____ To: _____
Abbreviated Description of Duties Performed			Hours Worked per Week		Reason for leaving
2. Company Name			Company Address (Street, City, State, Zip)		
Job Title			Type of Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Date of Employment From: _____ To: _____
Abbreviated Description of Duties Performed			Hours Worked per Week		Reason for leaving
3. Company Name			Company Address (Street, City, State, Zip)		
Job Title			Type of Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Date of Employment From: _____ To: _____
Abbreviated Description of Duties Performed			Hours Worked per Week		Reason for leaving
4. Company Name			Company Address (Street, City, State, Zip)		
Job Title			Type of Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Date of Employment From: _____ To: _____
Abbreviated Description of Duties Performed			Hours Worked per Week		Reason for leaving
5. Company Name			Company Address (Street, City, State, Zip)		
Job Title			Type of Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Date of Employment From: _____ To: _____
Abbreviated Description of Duties Performed			Hours Worked per Week		Reason for leaving

PART V: Personal History Information

If you answer "yes" to any of the questions below (1-15), you must attach a full written explanation pertaining to that particular question.

1. Has your physician assistant certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Have you ever had an application to practice as a physician assistant denied or refused by another licensing board or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you ever voluntarily surrendered a physician assistant license/certificate, controlled substance registration or DEA registration?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Are you currently under investigation or the subject of pending disciplinary action by any licensing board, health care facility or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Is your physician assistant license/certificate currently restricted in any way by any licensing board, health care facility or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If yes, how many? _____ (Complete the attached malpractice form, if applicable)	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Currently or within the last ten years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant?	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a physician assistant?	YES <input type="checkbox"/> NO <input type="checkbox"/>
11. Has your ability to practice as a physician assistant ever been impaired by any physical or mental illness or by the use of alcohol or drugs?	YES <input type="checkbox"/> NO <input type="checkbox"/>
12. Have you ever discontinued practicing as a physician assistant for any reason for one month or more?	YES <input type="checkbox"/> NO <input type="checkbox"/>
13. Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
14. Currently or within the last ten years, have you been arrested, indicted, or convicted, pled guilty, or pled <u>nolo contendere</u> for violation of any federal, state, or local law (other than a minor traffic violation)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
15. Have you ever been known by any other name or surname?	YES <input type="checkbox"/> NO <input type="checkbox"/>

For Board Member use only

Applicant Signature _____

Date _____

Board Member Signature _____

Date _____

PART VI: Physician Supervisor/Supervising Physician Information

1. Last Name		2. First Name		3. Middle Name		4. Suffix (Jr., III)		
5. Title M.D. <input type="checkbox"/> D.O. <input type="checkbox"/>			6. Maiden Name			7. Social Security Number/Alien ID*		
8. Mailing Address (Street or PO Box, City, State, Zip)								
9. Home Address (Street, City, State, Zip – not PO Box)						9a. Home Congressional District		
9b. Home Phone			9c. Home Fax			9d. Home Email		
10. Business Name			10a. Business Address (Street, City, State, Zip – not PO Box)					
10b. Business Phone			10c. Business Fax			10d. Business Email		

11. SC License Number _____ Type of Practice _____

12. List any certification by ABMS/AOA approved specialty board(s): _____

13. List name and location of any hospital or other offices (other than your own) where you request this Physician assistant to assist you:

Hospital/Office	Location
_____	_____
_____	_____
_____	_____

14. The following list of task are approved for all physician assistants:

- | | |
|------------------------------|-----------------------------|
| Local anesthesia | Suture lacerations |
| Pap smears | Catheterization |
| Start IV's/Flush port-a-cath | Venipuncture |
| Assist in Surgery | Cauterize benign lesions |
| Skin biopsy | Removal of ingrown toenails |
| Removal of foreign bodies | Coordinate clinical studies |
| Wound management | Aspirated joint |

15. Scope of Practice Guidelines must accompany your application. These guidelines must be practice specific and clearly specify in detail those tasks for which approval is being sought.

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:

- a) name, license number, and practice addresses of all supervising physicians;
- b) name and practice address of the physician assistant;
- c) date the guidelines were developed and dates they were reviewed and amended;
- d) medical conditions for which therapies may be initiated, continued, or modified;
- e) treatments that may be initiated, continued and modified;
- f) drug therapy, if any, that may be prescribed within the usual scope of the supervising physician's practice; and
- g) situations that require direct evaluation by or immediate referral to the physician.

PART VII: Physician Supervisor/Supervising Physician Information
(Continued)

I hereby certify that the foregoing is correct and true, and I assume responsibility for supervising all tasks performed by my physician assistant under my supervision. It is my responsibility to inform all approved alternate supervising physicians of the responsibilities of supervising my physician assistant.

Primary Supervising Physician Signature	SC License No.	Date
Alternate Supervising Physician Signature	S.C. License No.	Date
Alternate Supervising Physician Signature	S.C. License No.	Date
Alternate Supervising Physician Signature	S.C. License No.	Date
Alternate Supervising Physician Signature	S.C. License No.	Date
Alternate Supervising Physician Signature	S.C. License No.	Date
Alternate Supervising Physician Signature	S.C. License No.	Date

(Attach an additional sheet, if needed.)

PART VIII: Letters of Recommendation

Please list below names and addresses of three individuals willing to write letters of recommendation to support your application for physician assistant licensure in South Carolina. Two letters must be from physicians and the third may be from a physician assistant familiar with your work. **You must request that these individuals write directly to this Board (on letterhead)** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for Physician assistant licensure in South Carolina. **Your application will not be considered complete until letters of reference from three individuals below and all other materials necessary to support your application have been received.**

1. Name _____ telephone () _____
 Address _____ City, State, Zip _____
2. Name _____ telephone () _____
 Address _____ City, State, Zip _____
3. Name _____ telephone () _____
 Address _____ City, State, Zip _____

PART IX: Certifying Statement

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as a physician assistant in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice as a physician assistant in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

Signature of Applicant (Do not print)

Printed Name of Applicant

Date

Subscribed and sworn to before me this _____ day of

_____, _____.

Notary Public Signature

My Commission Expires: _____

Attach passport photo here

(2x2)

Passport size

No copies

Do Not Staple

For Office Use Only

Date Received: _____

Paid by: Check Money Order Cash

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

South Carolina Department of Labor, Licensing and Regulation
PO Box 11329
Columbia, SC 29211

AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10 SC Code of Law, **ALL** applicants for a South Carolina license after July 1, 2008 are required to complete and sign this Affidavit of Eligibility.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

- 1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or
- 2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
 - a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
 - b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.
- 3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
 - a. ___ I am a US citizen, not physically present or employed in the United States.
 - b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided **upon request only**.

- Any South Carolina Driver License, South Carolina Driver Permit or South Carolina Identification Card, expired less than one year.
- Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year. State: _____
- Valid Temporary Resident Card
- Certificate of Naturalization with intact photo
- Certificate of (US) Citizenship with intact photo
- Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

(If issued by a state agency, include both the state and agency name.)

_____/_____/_____

Social Security Number

3. What is the secure and verifiable document number? _____

4. What is the expiration date of your secure and verifiable document? ____/____/____ (month/day/year)

(If you hold a document without an expiration date, such as a military ID or naturalization certificate, write N/A.)

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States. I may also be required to provide proof of lawful presence.
- I understand that in accordance with section 8-29-10 false statements made herein are punishable by law. I state under penalty of perjury that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Labor, Licensing and Regulation upon request and is subject to verification.

Signature

Date

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Code of Laws requires that every individual who applies for an occupational or professional license provide a social security or alien identification number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

This space for office use only

This space for office use only

Temporary License Information

Temporary License No: _____

Issue date: _____

Expiration date: _____

**APPLICATION FOR A LICENSE TO PRACTICE AS
A PHYSICIAN ASSISTANT**

Issued by the

**SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING AND REGULATION**

Board of Medical Examiners

110 Centerview Drive, Suite 306
P.O. Box 12517
Columbia, South Carolina 29211
(803) 896-4501

Interviewed/Approved by Board Member

Date

Board Member Signature

Important: Bring your original diplomas, other state licenses, scope of practice guidelines and NCCPA Certification when you appear for the interview.



South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, Suite 306
P.O. Box 12517
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(803) 896-4501



Applicant's Name _____
First Middle Last

I am applying for a license to practice as a physician assistant in South Carolina. Please complete this form bearing the institution's official seal to the address above.

Applicant's Signature Date

CERTIFICATION OF PHYSICIAN ASSISTANT EDUCATION

It is hereby certified that _____
of (home town, state and country) _____
attended (full name of program) _____
from _____ to _____ and received a diploma
conferring the degree of _____ and said diploma bears
the following date _____.

(Seal)

(Dean, Registrar, P.A. Program Director)

Current Date _____



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Physician Assistant Verification of Licensure

Complete the top portion of this form and forward a copy to each state board by which you are now or ever been licensed/certified to practice as a physician assist. You may want to contact each state to see if a fee is required.

In applying for a license to practice medicine in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address:

PLEASE TYPE OR PRINT

Signature _____

Name _____

Address _____

City _____ State _____ Zip _____

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____ Date of degree: _____

State of: _____ License number: _____ Date issued: _____

License is current _____ If no, why not? _____

Has license been suspended, revoked, or restricted? _____ If yes, why? _____

Comments, if any _____

Date: _____

Signature: _____

Board Seal

Title: _____

State Board: _____



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

110Centerview Drive, Suite 306, P.O. Box 12517
Columbia, South Carolina 29211
(803) 896-4501

Insert 3



PHYSICIAN ASSISTANT STATE EXAM

This exam is considered part of the application process and must be returned to the Board along with the application. Please answer “true or false”. Visit our website at www.llr.state.sc.us/pol/medical for a copy of the South Carolina Physician Assistant Practice Act.

- | | True or False |
|--|---------------|
| 1. The Physician Assistant Committee is made up of seven Physician Assistants to serve as an advisory committee to the State Board of Medical Examiners. | _____ |
| 2. Physician Assistants in South Carolina are no longer certified; they are now licensed. | _____ |
| 3. Physician Assistants in South Carolina are allowed to sign for and dispense pharmaceutical samples including Class III and IV controlled substances. | _____ |
| 4. A Physician Assistants license must be renewed every other year on or before January first. | _____ |
| 5. A temporary license to practice may be granted to a Physician Assistant without the scope of practice guidelines. | _____ |
| 6. After a Physician Assistant is approved for a temporary license, the Committee will meet and issue a permanent license, extend the temporary license, or withdraw the temporary license. | _____ |
| 7. Physician Supervisor means a South Carolina licensed physician currently possessing an active unrestricted permanent license to practice medicine in South Carolina who is approved to supervise no more than two Physician Assistants. | _____ |
| 8. Current NCCPA Certification is not required to obtain a permanent license to practice as a Physician Assistant in South Carolina. | _____ |
| 9. A Physician Assistant may not practice at any location more than forty-five miles or sixty minutes travel time from the Supervising Physician without written approval of the Board. | _____ |
| 10. A Physician Assistant may not perform a task which has not been listed and approved on the scope of practice guidelines on file with the Board. | _____ |
| 11. A physician who has supervised a licensed Physician Assistant for a period of at least six months, or a Physician Assistant who has been licensed for at least one year, may request on-the-job training for the Physician Assistant. | _____ |
| 12. If the supervisory relationship between the Physician Assistant and the Supervising Physician is terminated for any reason, the Board must be notified within six months. | _____ |
| 13. A Physician Assistant may prescribe Phenobarbital. | _____ |
| 14. When the Supervising Physician is not present at the practice site, he must review, initial and date the charts of patients seen by the Physician Assistant within 72 hours. | _____ |
| 15. All tasks of the Physician Assistant are identified in the scope of practice guidelines. | _____ |
| 16. A Physician Assistant may practice in the absence of his/her supervising physician 50% of the time. | _____ |
| 17. Prescriptive Authority is not needed to request, receive or sign for professional samples. | _____ |
| 18. “Supervising” means overseeing the activities of, and accepting responsibility for the medical services rendered by a Physician Assistant in a manner approved by the board. | _____ |
| 19. A Physician Assistant may not perform any task that is outside the usual scope of the Supervising Physician’s practice. | _____ |
| 20. In the event of the termination of the employment agreement between the Physician Assistant and the primary Supervising Physician, the Alternate Supervising Physician may assume the responsibility. | _____ |

Physician Assistant Signature

Print Name

Date



South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
 110 Centerview Drive, Suite 306, P.O. Box 12517
 Columbia, South Carolina 29211
 (803) 896-4501



Insert 4

APPLICATION FOR PRESCRIPTIVE AUTHORITY

PHYSICIAN ASSISTANT NAME: _____

I acknowledge, understand, and assume my responsibilities as supervising physician of the above named Physician Assistant for prescriptive authority. I understand that should a Physician Assistant acting under my supervision engage in illegal conduct, I shall be subject to discipline under the Medical Practice Act. I further understand and agree that if the Physician Assistant engages in any unprofessional, unethical or illegal conduct, that I will promptly report such action in writing to the State Board of Medical Examiners of South Carolina.

The Medication formulary shall consist of those medications appropriate to the treatment of patients in this practice setting including prescribing medical devices, excluding any Substance II Controlled Medications, Ophthalmic Steroids, MAO inhibitors, Anabolic Steroids, Sublingual Nifedipine for Blood Pressure control or initiation of Class III Antiarrhythmics. Acutane (Isotretinoin), Blood products, and Chemotherapy agents may be approved for refill only. Toradol may not be prescribed for more than 5 days.

If the Physician Assistant wishes to prescribe Schedule III-V drugs, an application for a Controlled Substances registration must be obtained from DHEC-Division of Narcotic and Drug Control for a controlled substance license at (803) 896-0634.

Supervising Physician Signature

Date

Physician Assistant Signature

Date

=====

BOARD APPROVAL:

PRESCRIPTIVE AUTHORITY NUMBER: _____

APPROVED BY BOARD: _____ **DATE:** _____

Prescriptive Authority fee: \$40

CONTROL # _____
CHECK # _____
AMOUNT \$ _____



South Carolina Department of Labor, Licensing & Regulation
Board of Medical Examiners
110 Centerview Drive, Suite 306, P.O. Box 12517
Columbia, South Carolina 29211
Telephone (803) 896-4501



MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

Physician Assistant name Office telephone no.

Address City State Zip

MALPRACTICE COMPLAINT: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Patient's Name:

Age: Sex:

Date/place of occurrence:

Indicate your position in case, i.e., resident, primary physician, etc.:

FILED AGAINST: () Individual Doctor () Group () Hospital

List names of other defendant-doctors and/or hospitals:

DISPOSITION: () Pending () Jury Verdict () Settled () Dismissed () Dropped

If there has been a verdict or settlement, please provide the following information:

Legal outcome:

Date: Total amt. paid (if any):

Amount attributable to you:

- 1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Date: Signature:

ATTENTION CHECK WRITERS!!!

WE GLADLY ACCEPT YOUR CHECKS.
WHEN YOU PROVIDE A CHECK AS PAYMENT, YOU
AUTHORIZE US TO USE INFORMATION FROM THE CHECK
TO MAKE A ONE-TIME ELECTRONIC FUND TRANSFER
FROM YOUR ACCOUNT, OR TO PROCESS THE PAYMENT AS
A CHECK TRANSACTION.

YOU AUTHORIZE US TO COLLECT A FEE THROUGH
ELECTRONIC FUND TRANSFER FROM YOUR ACCOUNT IF
YOUR PAYMENT IS RETURNED UNPAID.