



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

VOLUNTEER LIMITED LICENSE RENEWAL APPLICATION

NOTE: Application must be fully completed with all requested information and documentation supplied.

(Please type or print clearly)

I hereby make application to renew my current volunteer limited license application in the state of South Carolina and submit the following statement of facts with the required supporting documents.

Applicant's Name _____
Last First Middle

Home Address:

SC Practice Information:

Street address

Hospital/Clinic

City State Zip

Street address

Home telephone number

City State Zip

*Social Security Number

Office telephone number

Date of birth: _____
Month Day Year

Type of practice: _____

*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 medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

SC Volunteer Limited License No.: _____

Supervising physician name _____

Supervising physician name _____

PERSONAL DATA

****If you are currently enrolled in the Recovering Professional Program (RPP), you may answer "No" to this question.**

Since you last applied to this Board for your volunteer limited license:

Answer Yes or No

1. Has your medical license been revoked, suspended, reprimanded, restricted or placed on probation by any medical licensing board or other entity? _____
2. Have you had an application to practice medicine denied or refused by another medical licensing board or entity? _____
3. Have you had hospital privileges denied, revoked, suspended or restricted in any way? _____
4. Have you voluntarily surrendered a medical license, controlled substance registration or DEA registration? _____
5. Have you resigned from any hospital, institution or health care facility in lieu of disciplinary action? _____
6. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? _____
7. Is your medical license currently restricted in any way by any medical licensing board, or other entity? _____
8. Have you had a malpractice lawsuit, judgment or settlement filed against you?
If so, how many? _____
9. 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?*** _____
10. 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?*** _____
11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____
12. Have you discontinued the practice of medicine for any reason for one month or more? _____
13. Has your ability to prescribe controlled substances been denied, revoked, suspended or limited by any hospital, health care facility or other entity? _____
14. Have you been arrested, indicted, or convicted, pled guilty or pled nolo contendere for violation of any federal, state or local law(other than a minor traffic violation)? _____
15. Have you ever been known by any other name or surname? _____

NOTE: If you answered "Yes" to any of the above questions (1-15), you must attach a full written explanation pertaining to that particular question.

I have carefully read all questions in this application and have answered them fully, accurately, and completely. I hereby agree that my failure to answer all questions or make full disclosure of any facts or information called for in this application shall constitute cause for the denial of my application or for the revocation of my license to practice medicine in South Carolina. Further, I hereby acknowledge and agree that I shall receive no payment or compensation, either direct or indirect, or have any expectation of payment or compensation for any medical services I render while practicing in South Carolina. I further agree that receipt of payment of compensation, either monetary or in kind, for the provision of medical services, shall constitute a violation of law.

Signature: _____ Date: _____