



Complete all sections of this application by providing all of the requested information. You must notify the Board, in writing, of any address changes after you file this application in order to receive any further information. The application form itself is a public document obtainable under the Freedom of Information Act.

Applying for: Licensed Acupuncturist Auricular Therapist Auricular Detoxification Therapist

PART I: Applicant Identifying Information

1. Last Name		2. First Name		3. Middle Name		4. Suffix (Jr., III)	
5. Title <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.				6. Maiden Name			
7. Mailing Address (Street or PO Box, City, State, Zip)							
8. Home Address (Street, City, State, Zip)						8a. County (SC Only)	
8b. Home Phone		8c. Home Fax		8d. Home Email			
9. Business Name			9a. Business Address (Street address, not PO Box, City, State, Zip)				
9b. Business Phone		9c. Business Fax		9d. Business Email			
10. Place of Birth (List City & State or Country)		11. Date of Birth MM/DD/YYYY	12. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	13. 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 and State or Country)	DATES OF ATTENDANCE		GRADUATED Yes/No	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		

Are you a graduate from a program outside the United States? YES NO

Professional Education

List in chronological order from date of graduation to the present all professional education not including continuing education coursework (i.e., apprenticeship, intern, residency, vocational training practical or clinical training.).

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM YES <input type="checkbox"/> NO <input type="checkbox"/>
		FROM (Month/Year)	TO (Month/Year)	
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <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.

PART III: Record of Licensure Examination

Complete the requested information below to include examinations taken in this state or any other state. Use additional paper if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination	State or Country	Date of Examination	Number of Attempts	Passed/Failed/Score (If score, enter score)

PART IV: Record of Licensure Information

Complete the requested information below if you have ever been licensed, certified or registered to practice in any profession or occupation. You must identify the method by which you obtained your license(s). You must include jurisdiction both within and outside the United States. 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	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date of <u>Initial</u> Issuance
State or Country of Original (Initial) Licensure:				
State or Country of Current licensure where you most recently practiced:				

List Other Jurisdictions of Licensure:

PART V: Employment History		
List all related employment chronologically 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 in Box 1. You are authorized to photocopy this form 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 VI: Personal History Information

If you answer “yes” to any of the questions below (1-11), you must attach a full written explanation pertaining to that particular question.

1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority? YES NO

2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? YES NO

3. Have you ever been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility, or staff of such facility? YES NO

4. Have your privileges ever been restricted or terminated by any association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures? YES NO

5. To your knowledge have any unresolved or pending complaints ever been filed against you with any federal or state agency, professional association, licensed hospital/clinic, or staff of such hospital or clinic? YES NO

6. Have you ever been arrested, indicted or convicted (including a nolo contendere plea or guilty plea) for violation of any federal, state or local law (other than minor traffic violations)?
If yes, have a certified copy of the court records regarding your conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above mentioned authorities. YES NO

7. Currently or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice? YES NO

8. Have you ever been court martialled or discharged other than honorably from the armed service? YES NO

9. Currently or within the last five 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? YES NO

10. Currently or within the last five years have you developed any disease or conditions, physical, mental or emotional that might interfere with your ability to competently and safely perform the essential functions of practice? YES NO

11. Have you been known by any other name or surname? YES NO

PART VII: AFFIDAVIT

I, _____ (print name), am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. 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 act shall constitute the cause for denial or revocation of my license to practice as an Acupuncturist in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (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 qualifications for acupuncture practice 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, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incorrect information in this application, I hereby agree that such act may constitute cause for denial or revocation of my license to practice in South Carolina.

I hereby authorize the South Carolina Board of Medical Examiners to utilize my Social Security Number (SSN) in making necessary reports to the Federation of State Medical Boards' Physicians Data Center for compilation of information about applicants and licenses in order to coordinate licensure and disciplinary activities between the individual states' licensing boards, and to federal and state entities, as required by law.

Signature of Applicant (Do not print)

Printed Name of Applicant

Subscribed and sworn before me this _____ day of _____, 20_____.

Notary Public

My Commission Expires: _____

Attach Photo Here
(2x2)
No copies
Do Not Staple

INTERVIEW AND APPROVAL

Committee/
Board Member _____

Date approved _____

For Office Use Only	
Date Received:	_____
Paid by:	<input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Cash
Check/Money Order No:	_____ Amount: _____
Control No.	_____ Deposit No. _____

South Carolina Department of Labor, Licensing and Regulation
PO Box 11289
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.)

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

Last, First & Middle Name _____
www.llr.state.sc.us/pol/medical

_____/_____/_____

Social Security 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.

Summary of Requirements for Acupuncture Practice

Applicants applying for a license to practice acupuncture must submit the following documentation:

1. Completed original application. (Copies not accepted). This includes the Affidavit of Eligibility.
2. Fee - Non-refundable application fee of \$111.00 is required with your application. Your application will not be processed until the \$111.00 application fee has been received. Make check payable to **LLR-Board of Medical Examiners**.
3. Submit a copy of your acupuncture diploma.
4. Submit a copy of your active certification in acupuncture by the National Commission for the Certification of Acupuncturists and Oriental Medicine (NCCAOM).
5. Verification of licensure – A verification form is enclosed and may be duplicated as needed. This Board must receive verification of licensure directly from the state board of each state in which you are now or have ever been licensed to practice acupuncture.
6. Interview and temporary license - When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will 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. During this interview you must present your original diplomas and training certificate, if applicable.

Please note:

1. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within three weeks of received date.
2. Please mail, fax or email your address changes in writing immediately to the Board.
3. It is a violation of state law if an acupuncturist practices before being issued a license. Violators are subject to fines and possible criminal prosecution.

Summary of Requirements to Perform Auricular Therapy

Applicants applying for a license to perform Auricular Therapy must submit the following documentation:

- (1) Completed original application. (Copies not accepted)
- (2) Fee - Non-refundable application fee of \$111.00 is required with your application. Your application will not be processed until this \$111.00 application fee has been received. Make check payable to **LLR-Board of Medical Examiners**.
- (3) Submit a copy of your certification as having been trained to utilize auricular points.
- (4) Successful completion of a national certified program approved by the Acupuncture Advisory Committee and the State Board of Medical Examiners;
- (5) Copy of your certificate documenting successful completion of a nationally recognized clean needle technique course.
- (6) Verification of licensure – A verification form is enclosed and may be duplicated as needed. This Board must receive verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice auricular therapy.
- (7) Supervisor form completed. Auricular therapy may take place under the supervision of a licensed acupuncturist or a person licensed to practice medicine.
- (8) Interview and temporary license - When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will 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. During this interview you must present your original diplomas and training certificate, if applicable.

Please note:

1. 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.
2. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within three weeks of received date.
3. Please mail, fax or email your address changes in writing immediately to the Board.
4. It is a violation of state law if an acupuncturist practices before being issued a license. Violators are subject to fines and possible criminal prosecution.

Summary of Requirements to Perform Auricular Detoxification Therapy

Applicants applying for a license to perform Auricular Detoxification Therapy must submit the following documentation:

- (1) Completed original application. (Copies not accepted)
- (2) Fee - Non-refundable application fee of \$111.00 is required with your application. Your application will not be processed until this \$111.00 application fee has been received. Make check payable to **LLR-Board of Medical Examiners**.
- (3) Copy of your certificate documenting that you have successfully completed a nationally recognized training program in auricular detoxification therapy for the treatment of chemical dependency detoxification and substance abuse.
- (4) Copy of your certificate documenting successfully completion a nationally recognized clean needle technique course.
- (5) Verification of licensure – A verification form is enclosed and may be duplicated as needed. This Board must receive verification of licensure directly from the state board of each state in which you are now or have ever been licensed to practice auricular Detoxification therapy.
- (6) Supervisor form completed. Auricular detoxification therapy may take place under the direct supervision of a licensed acupuncturist or a person licensed to practice medicine.
- (7) Interview and temporary license - When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will 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. During this interview you must present your original diplomas and training certificate, if applicable.

Please note:

1. Treatment by an auricular detoxification therapist is strictly limited to the five ear-point treatment protocol for detoxification, substance abuse, or chemical dependency as stipulated by the National Acupuncture Detoxification Association (NADA).
2. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within three weeks of received date.
3. Please mail, fax or email your address changes in writing immediately to the Board.
4. It is a violation of state law if an auricular detoxification therapist practices before being issued a license. Violators are subject to fines and possible criminal prosecution.

**Information below is to be completed by the
SUPERVISING PHYSICIAN OR ACUPUNCTURIST
For an
Auricular Therapist or Auricular Detoxification Therapist**

(Please type or print clearly)

SC License Number: _____

Name: _____

First

Middle

Last name

Address: _____

City: _____ State: _____ Zip: _____

Home telephone: () _____ Office telephone: () _____

1. List and attach copies of all acupuncture training.

School

Course

Date completed

2. Describe below the nature of the working relationship for the auricular therapist or auricular detoxification therapist. (Attach additional pages if necessary)

3. Describe below the types of conditions for which acupuncture will take place. (Attach additional pages if necessary)

- I acknowledge and agree, if approved by the Board, that I shall be responsible for supervising the auricular therapist or directly supervising of the auricular detoxification therapist named in this application. I further acknowledge that as the supervising physician or acupuncturist, I will be available to attend to any unexpected, adverse effects.
- I agree that should I become aware of any unethical, unprofessional or illegal acts or omissions on the part of the auricular therapist or auricular detoxification therapist, I shall immediately report such conduct in writing to the State Board of Medical Examiners of South Carolina.
- I have carefully read the above questions and answered them completely and I declare that all statements made by me herein and materials supplied herewith are true and correct. Further, if approved as the supervising physician or acupuncturist of this auricular therapist or auricular detoxification therapist, **I agree to keep the Board informed of any future changes in my address or working relationship with this auricular therapist or auricular detoxification therapist.**

Name of Auricular Therapist or Auricular Detoxification Therapist

(Date)

(Supervising physician or acupuncturist signature)

Last, First & Middle Name _____
www.llr.state.sc.us/pol/medical

ACUPUNCTURE VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you have now or have ever been licensed to practice acupuncture, auricular therapy or auricular detoxification therapy.

In applying for a license to practice acupuncture 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 certificate or license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding myself, directly to:

SC Dept. of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive
P. O. Box 11289
Columbia, SC 29211
(803) 896-4500

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 Board of Medical Examiners.

This certifies that the records of the _____ Board of Medical Examiners indicate that _____ was issued license number _____ certificate number _____ on _____ 19____ to practice acupuncture.

Certificate or license is current? _____ If no, why not? _____

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

Has applicant ever been requested to appear before your Board? _____ If Yes, why? _____

Derogatory information, if any _____

Comments, if any _____

Signature: _____

Title: _____

BOARD SEAL

Date: _____