South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, Suite 202, P.O. Box 11289
Columbia, SC 29211-1289
(803) 896-4500

APPLICATON FOR PHYSICIAN ASSISTANT CHANGE OF SUPERVISOR OR ADDITIONAL SUPERVISOR

(Please check one of the following)

PA License Number: ______________

____________ **CHANGE OF SUPERVISOR APPLICATION**
____________ **CHANGE OF SUPERVISOR APPLICATION WITHIN THE SAME PRACTICE**
____________ **REQUEST FOR AN ADDITIONAL SUPERVISOR (Please advise who is first primary, second, etc.)**

Application must be fully completed with all requested information and documentation supplied. **Application fee of $25.00** must accompany application; **application fee is non-refundable (Additional $40 for Prescriptive Authority).** I hereby make application to the State Board of Medical Examiners of South Carolina for a Physician Assistant license in the State of South Carolina and submit the following statement of facts with the required supporting documents. *This application form itself is a public document obtainable under the Freedom of Information Act.*

Applicant's Name: ____
Last First Middle

Home Address: ____
Street City State Zip

Home Phone: ( ) ____________________ Business Phone: ( ) ____________________

Proposed Supervising Physician: ____
Last First Middle

Address: ____
Street City State Zip

I. EMPLOYMENT ACTIVITIES

1. List all activities chronologically:

Office address and Location	From Mo./Day/Yr	To Mo./Day/Yr.

2. NCCPA Certificate Number:____________________ (please attach copy) Expiration Date: ____________________

CONTROL # ____________________

CHECK # ____________________

AMOUNT ____________________

Revised 3/07

II. PERSONAL DATA

Answer Yes or No

1. Since your last application, has your physician assistant certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? ________________

2. Since your last application, have you had an application to practice as a physician assistant denied or refused by another licensing board or entity? ________________

3. Since your last application, have you had hospital privileges denied, revoked, suspended or restricted in any way? ________________

4. Since your last application, have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? ________________

5. Since your last application, have you been under any investigation or the subject of pending disciplinary action by any licensing board or other entity? ________________

6. Since your last application, has your physician assistant certificate/license been restricted in any way by any licensing board, health care facility or other entity? ________________

7. Since your last application, have you had a malpractice lawsuit, judgment or settlement filed against you? If so, how many? ______________________ ________________

8. Since your last application, 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? ________________

9. Since your last application, 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? ________________

10. Since your last application 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? ________________

11. Since your last application, have you discontinued practicing as a physician assistant for any reason for one month or more? ________________

12. Since your last application or within the last ten years, have you ever been arrested, indicted, or convicted, pled guilty, pled nolo contendere for violation of any federal, state or local law (Other than a minor traffic violation)? ________________

13. Since your last application, have you voluntarily surrendered a physician assistant certificate/license, controlled substance registration or DEA registration? ________________

14. Since your last application, has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity? ________________

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.

For Board Member Use only

____	________________
Board Member Signature	Date
____	________________
Applicant Signature	Date

III. SUPERVISING PHYSICIAN

This information is to be completed by the proposed Supervising Physician:

1. Full Legal Name: ______________________________ S.C. License No.: ____________

2. Office Mailing Address: ____
Street City State Zip

   Office Phone #: (   ) ____________________ Home Phone #: (   ) ____________________

3. Home Address: ____
Street City State Zip

4. Type of Practice: ____

5. List any certification by ABMS approved specialty board(s): ______________________________

6. 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
______________________	______________________
______________________	______________________

The following list of tasks 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	

A physician assistant practicing at all sites shall practice pursuant to written scope of practice guidelines signed by all supervising 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.

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

III. SUPERVISING PHYSICIAN

(Continued)

I hereby certify that the foregoing is true and correct, 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.

______________________________	______________	______________
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 additional sheet, if needed.)

IV. AFFIDAVIT

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 reservation 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 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.

Applicant's Signature: ___________________________________ Date: ______________________________

Subscribed and sworn to before me this _________________ day of ______________________________, ___________.

______________________________	______________________________
Notary Public Signature	My Commission Expires:

THIS SPACE FOR BOARD USE ONLY

Interviewed/approved by Board Member:
Date approved
Board Member Signature

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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 $______________________________

Mark Sanford
Governor

Adrienne Riggins Youmans
Director

South Carolina
Department of Labor, Licensing and Regulation

Board of Medical Examiners

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Affidavit for Controlled Substance Prescribing Privilege

Pursuant to Section 40-47-965 (B) of the 1976 Code of Laws, amended, this is to confirm under oath and penalty of law that I have completed the requirements of the State Board of Medical Examiners (the Board) regarding the authorization of licensed Physician Assistants in South Carolina to prescribe Controlled Substances in Schedules III-V (excluding Schedule II).

I hereby certify that I am duly licensed in South Carolina as a Physician Assistant based upon current certification by the NCCPA, which includes not less that 60 contact hours of pharmacotherapeutics. I further certify that I have successfully completed at least 15 contact hours of education in controlled substances acceptable to the Board. Documentation is available from me upon request.

I further certify that my scope of practice guidelines include prescribing controlled substances in Schedules III-V (excluding Schedule II), as approved by my Supervising Physician.

This affidavit shall serve as an addendum to my approved scope of practice guidelines on file with the Board. It is further understood that I must register with DHEC-Drug Control before prescribing any controlled substances. Under no circumstance will I prescribe for Schedule II drugs.

____

Physician Assistant (Signature)

____

Supervising Physician (Signature)

Subscribed and sworn to before me this ________day of _______________________, _______________.

____   ____________________________

Notary Public Signature   My Commission Expires

(Only this form is to be completed and returned to the Board office along with the application -the following pages (7-9) should be maintained at all practice sites for inspection upon request by the Board)

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Mark Sanford
Governor

Adrienne Riggins Youmans
Director

TO: All South Carolina Licensed Physician Assistants and Supervising Physicians

RE: Management of Expanded Prescriptive Authority for Physician Assistants in South Carolina

The following information was developed to help licensed Physician Assistants in South Carolina in their practice of prescribing controlled substances. You must maintain a copy of this document at all practice sites for inspection upon request by the Board of Medical Examiners or its agent. New rules effective March 15, 2006, give Physician Assistants the ability to prescribe controlled substances upon obtaining a DEA number, registering with the South Carolina Department of Health and Environmental Control's Bureau of Drug Control and signing, with their primary supervising physician, the following document approved by the Board. Spaces are provided at the end of this document for your convenience in fulfilling that responsibility.

Management of Controlled Substances Prescriptive Authority for Physician Assistants in South Carolina

The South Carolina Board of Medical Examiners is charged by law to regulate properly the practice of medicine and surgery for the benefit and protection of the people of the State. Many prescribers are asked to appear before the Board because of a lack of information about the management and responsibilities involved in prescribing controlled substances. The typical inadvertent offender is likely to be a prescriber with a sincere attitude and a desire to relieve pain and misery, but who is also pressed for time and prescribes controlled drugs at patient demand over prolonged periods without adequate documentation. Problem prescriptions are often for chronic ailments such as headache, arthritis, vague old injuries, chronic orthopedic problems, backache or anxiety. (Terminal cancer pain management is not a consideration here.)

It is not what you prescribe; rather it is how well you manage the patient's care and document the treatment in legible form. Prescribing matters which come before the Board are almost always related to controlled substances. A majority of instances where licensees have been disciplined by the Board for prescribing practices could have been avoided completely if the steps outlined here were followed.

The Board does not have a list of **"bad" or "disallowed"** drugs. Any drug approved by your supervising physician may be prescribed and administered when properly indicated and, conversely, may be harmful or even lethal when used inappropriately. There is no magic formula for determining the dosage and duration of administration for any drug. Prescribing must be determined within the confines of the individual case and continued under proper monitoring. What is good for one patient may be insufficient or fatal for another. The Board expects licensees to create a record that shows:

- Proper indication and route for the use of drug or other therapy;
- The dosage and volume prescribed (including any refills);
- Monitoring of the patient when necessary or appropriate;
- The patient's response to therapy on follow-up visits;
- Rationale for continuing or modifying the therapy.

STEP ONE - Document an Adequate Examination: First and foremost, before you prescribe anything, start with a diagnosis which is supported by the history and physical findings of the patient being treated and by the results of any appropriate tests. Too many times a licensee must be asked why a particular drug was prescribed. An example of a typical response is, "Because the patient has arthritis." The licensee is asked, "How was that diagnosis reached?" and may answer, "Because that's what the patient complained of." In this example nothing in the record or in the licensee's recollection supports the diagnosis except the patient's assertion. **Do a workup sufficient to support your diagnosis,** including all the necessary studies and/or references to appropriately support the patient's diagnosis.

STEP TWO - Establish a Treatment Plan: Create a treatment plan, which includes the use of non-addictive modalities, if appropriate. Make referrals where appropriate and when included as a part of your written instruction. If referrals are made, the findings of the consultant should be included in the patient's chart.

STEP THREE - Try Conservative Modalities: Before beginning a regimen of addictive or dependence-producing drugs, make a determination through trial or a documented history of a trial that non-addictive modalities are not effective. A finding of intolerance or allergy to non-steroidal anti-inflammatory drugs is one thing, but the assertion of the patient that, "nothing seems to work like that Percodan stuff," is quite another. Many of the practitioners the Board has seen have started a treatment program with powerful controlled substances and did not consider other options or forms of treatment. This may be appropriate in acute settings.

STEP FOUR - Watch out for Drug Seekers: Be wary of the patient who, without adequate clinical symptoms, requests narcotic pain relief. Be alert also to the patient who lists multiple narcotic pain medications to which the requester has allegedly developed allergies and then names another which is well-tolerated. If you know the patient, review the prescription records in the patient's chart and discuss whether the patient has a history of chemical dependency before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum, obtain a verbal drug history, and discuss narcotic or chemical use and family chemical abuse history with the patient. Checking with pharmacies and pharmacy chains may tell you whether a patient is obtaining extra drugs or is prescription shopping.

STEP FIVE - Patient Education: As with any treatment, educate the patient before using a drug that has the potential to cause dependency problems. Take the time to explain the relative risks and benefits of the drug.

STEP SIX - Know the Patient's Environment: The family is a good source of information on behavioral changes, especially dysfunctional behavior. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be symptoms of dependency or addition. The family is also a good source of information on whether the patient is obtaining drugs from other sources or is self-medicating with other drugs or alcohol.

STEP SEVEN - Monitor the Patient: Maintain regular contact with the patient, including physical monitors. If the regimen is for prolonged narcotic use, a referral for a second opinion may be helpful. It is very important to monitor the patient for the status of the underlying disease, which necessitated the drug and for the potential side effects of the drug itself. This is true no matter what type of controlled substance is used or on what schedule it is listed. With certain conditions and certain drugs, a drug holiday may be appropriate. This could allow you to check the original symptoms during a time when the drug is not given, indicating continuing need for the drug or signaling that the duration of therapy has met its goal and that the medication may be discontinued.

STEP EIGHT - Control the Supply: Make sure you are in control of the supply of the drug. To do this, you must keep detailed records of the type, dose and amount of the drug prescribed. Some practitioners issue only written prescriptions and use multiple copy scripts or photocopies. You must also monitor, record and personally control refills. Do not authorize your office personnel to refill prescriptions. One good way to accomplish this is to require the patient to return to obtain refill authorization. Records of cumulative authorized dosing and average daily dosage can be valuable.

STEP NINE - Maintain Detailed Patient Records: It cannot be emphasized enough that one of the most frequent problems faced by a practitioner when the licensee comes before the Board or other outside review bodies is inadequate records. It is entirely possible that the practitioner did everything correctly in managing a case. Your medical records should be legible and understandable so that any outside reviewer can understand the process which you have followed to manage each patient.

This Document must be signed by the Physician Assistant and Supervising Physician stating they have read and understand the expanded prescribing privilege for Physician Assistants in South Carolina. A copy must be kept on file at each practice site. It must be reviewed biennially to ensure proper prescribing procedures are followed.

______________________________	______________________________
Physician Assistant Signature	**Date**
______________________________	______________________________
Supervising Physician Signature	**Date**

The Physician Assistant and Supervising Physician reviewed the preceding document on the following dates:

__________	______________________________	______________________________
Date	**Physician Assistant Signature**	**Supervising Physician Signature**

Date:	Signature	Signature
Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
Date:_________	**Physician Assistant Signature**	**Supervising Physician Signature**
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