



South Carolina Department of Labor, Licensing and Regulation

## South Carolina Board of

### Long Term Health Care Administrators

110 Centerview Dr. • Columbia • SC • 29210

P.O. Box 11329 • Columbia • SC 29211-1329

Phone: 803-896-4544 • [Contact.LTHCA@llr.sc.gov](mailto:Contact.LTHCA@llr.sc.gov) • Fax: 803-896-4515

[llr.sc.gov/lthc](http://llr.sc.gov/lthc)

## Qualifications for Reactivation of License

### Reactivation of Inactive License

A person seeking to reactive their inactive license may do so by completing the following:

- Submission of a completed reactivation application and payment of licensure fee(s).
- Submission of a complete Statement of Practice Affidavit.
- Provide proof of Continuing Education for each year that the license was inactive. See Continuing Education Guidelines for license specific requirements, <https://www.llr.sc.gov/lthc/ce.aspx>. If continuing education cannot be attained, a written statement attesting to this must be submitted and an appearance before the Board or re-examination may be required.

### Reactivation of Retired License

To qualify for a retired status, an applicant must have attained the age of sixty five (65) years or at least twenty (20) years of licensure and must affirm that he or she is not employed as the administrator in a nursing home of community residential care facility in South Carolina.

A person seeking to reactive their retired license may do so by completing the following:

- Submission of a completed reactivation application and payment of licensure fee(s).
- Submission of a complete Statement of Practice Affidavit.
- Provide proof of six (6) hours of Continuing Education during the previous twelve (12) months.
- Proof of additional fourteen (14) hours of continuing education within 90 days of the license being activated or the license will automatically be replaced in the retired status and the licensee must immediately cease and desist any work in a nursing home or community residential care facility in the State.

If the license has been retired for five (5) years or more, the board may require passing of the examination(s) in lieu of or in addition to the CE requirement.



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**Reactivation of Inactive Administrators Application**

**Submit the following with your application to the above address:**

- Check or money order only made payable to Long Term Health Care Administrators Board (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. **NO CASH IS ACCEPTED.**

**Reactivation Fees: NHA \$40      CRCFA \$35      Dual \$75**

- Statement of Practice Affidavit
- Documentation of required Continuing Education.
  - Per Board Regulations 93-150(E), licensees wishing to reactivate from inactive status must provide proof of annual continuing educational requirements for each year that the license was inactive. *Only half of CE hours may be obtained online. Courses must be Board approved or approved by NAB.*

**Annual Continuing Education Hours: NHA - 20    CRCFA – 18    Dual - 29**

**LICENSEE INFORMATION:**

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

License Number: \_\_\_\_\_ Type:  NHA     CRCFA     Dual

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

**CURRENT EMPLOYMENT:**

Primary Facility Name: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_

Facility Address: \_\_\_\_\_

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

Secondary Facility Name: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_

Facility Address: \_\_\_\_\_

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

**PERSONAL HISTORY QUESTION:**

Answer all the questions below; you are required to include a written statement with your application for any questions marked "Yes". If you answer "Yes" to a conviction; you will need to attach a criminal background check from your state of residence (i.e., SLED, etc.) and from the state where the conviction occurred.

- 1. Are you currently employed as the Administrator for a licensed facility in South Carolina?  Yes  No
- 2. Since your initial application or since your last renewal of your license with the Board have you been issued a final disciplinary order or entered into a Consent Agreement that includes a fine, probation, suspension, revocation or any restriction on the authorization to practice by the South Carolina Board of Long Term Health Care Administrators or any professional licensing board or any agency in this state or any other state or jurisdiction?  Yes  No
- 3. Since your initial application or since your last renewal of your license with the Board have you been convicted, pled guilty, or pled nolo contendere (no contest) to a felony, a crime involving the safety, health, or welfare of a patient or a crime involving drugs?  Yes  No
- 4. Do you currently have a mental or physical disability or addiction to alcohol, drugs or controlled substances to such a degree that may render further practice as a nursing home administrator or community residential care facility administrator or dangerous to the public or the patients of the nursing home or community residential care facility?  
*If you are enrolled in the South Carolina Recovering Professional Program and are in full compliance with that program, you may answer no regarding the portion of the question regarding addiction.*  Yes  No
- 5. Since your initial application or since your last renewal of your license with the Board, has there been YES NO any change in your name? (You must provide a copy of legal documents indicating change, if not previously provided.)  Yes  No
- 6. Since your initial application or since your last renewal of your license with the Board, has there been any change in the status of your lawful presence in the United States.  Yes  No

**ATTESTATION:**

I, \_\_\_\_\_, am the person described and identified, 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 nursing home administration and/or community residential care facility administration in South Carolina.

Applicant's Signature: \_\_\_\_\_

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

**PRIVACY DISCLOSURE:**

*South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security 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.*

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. 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 the application 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 services.



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**STATEMENT OF PRACTICE AFFIDAVIT**

***For all application for reinstatement, a complete Statement of Practice Affidavit must be included with the application.***

Since the lapse of my license, I attest to the following:

I have not engaged in the practice as an administrator in South Carolina

I have engaged in the practice as an administrator in South Carolina

Name of Facility: \_\_\_\_\_

Dates of Practice: \_\_\_\_\_

Explanation of Unlicensed Practice: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Sworn and Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Notary Signature

\_\_\_\_\_  
Print Name

Notary Public for the State of: \_\_\_\_\_

Commission Expiration: \_\_\_\_\_