

\*\*\*FOR OFFICE USE ONLY\*\*\*

Board Member Signatures

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\*\*\*FOR OFFICE USE ONLY\*\*\*

Date Received

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License Number:

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Issue Date:

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ID#:

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Receipt #:

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Signature of Board Administrator



**Rhode Island  
Board of Dietetics Practice**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For  
License As A***

Dietitian/Nutritionist

Graduate Practice

Yes       No

**Checklist**

Fee

Transcript

CDR

Verification(s)

Photo

Internship Form

**MILITARY STATUS ELIGIBILITY**

*(Documentation Required)  
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

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*LAST NAME*

*FIRST NAME*

*MI*

**DO NOT REMOVE THIS PAGE FROM APPLICATION**

**Phone: (401) 222-2828**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-1272**

# LICENSURE REQUIREMENTS

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- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$75.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- Official Transcripts with completion of Bachelor's or Masters Degree, from an accredited College or University, with a program in nutrition or dietetics sent directly from the college or university.
- Proof of valid registration mailed directly from the Commission on Dietetic Registration (if applicable)
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

## **Graduate Practice Dietitian/Nutritionist**

- Any graduate of an approved program in nutrition/dietetics, who has filed a completed application which includes all documents except exam scores (verified by CDR registration) may, upon receiving a temporary permit form the Department, perform as a dietitian/nutritionist under the supervision of a dietitian/nutritionist licensed in this state.

If such an applicant shall fail to pass the examination or to receive CDR registration, all aforementioned privileges shall automatically cease.

## **Licensure Information**

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

## **License Certificates**

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



# State of Rhode Island and Providence Plantations Board of Dietetics Practice

Application for License as a Dietitian/Nutritionist or Graduate Dietitian/Nutritionist

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

## 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

**NOTE:**  
It is your responsibility to notify the Department of Health Board of any name changes.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden Name, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

## 2. Social Security Number

 -  - 

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

## 3. Gender

Male

Female

## 4. Date of Birth

Month

Day

Year

## 5. Home Address

It is your responsibility to notify the board of all address changes.

No professional licensee's address (residence or business/employment) will be posted on the Department's Web site.

1st Line Address (Apartment/Suite/Room Number, etc.)

2nd Line Address (Number and Street)

City

Country, if NOT U.S.

Home Phone

Home Fax

State

Postal Code, if NOT U.S.

Home Fax

Zip Code

Postal Code, if NOT U.S.

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

## 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

**This address will appear on the Department of Health web site.**

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, if NOT U.S.

Business Phone

Extension

Business Fax

State

Postal Code, if NOT U.S.

Business Fax

Zip Code

Postal Code, if NOT U.S.

Business Fax

<p><b>7. Preferred Mailing Address</b> Please check <u>ONE</u></p>	<p><input type="checkbox"/> Please use my <b>Home Address</b> as my preferred mailing address</p> <p><input type="checkbox"/> Please use my <b>Business Address</b> as my preferred mailing address</p> <p><b>NOTE:</b> The preferred mailing address that you indicate is the address that will be released for all requests for that information.</p>
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<p><b>8. Qualifying Education</b></p> <p>Please list the name and information about the school that you attended that qualifies you for this license.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="height: 20px;"></td> </tr> <tr> <td>Type of School (University, College, Technical School, etc.)</td> </tr> <tr> <td style="height: 20px;"></td> </tr> <tr> <td>Name of School</td> </tr> <tr> <td>Date Graduated</td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table> <span style="margin: 0 10px;">Month</span> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <span style="margin: 0 10px;">Year</span> </td> </tr> <tr> <td style="height: 20px;"></td> </tr> <tr> <td>Degree Received</td> </tr> </table>		Type of School (University, College, Technical School, etc.)		Name of School	Date Graduated	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table> <span style="margin: 0 10px;">Month</span> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <span style="margin: 0 10px;">Year</span>					Degree Received
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Degree Received												

<p><b>9. Other State License(s)</b></p> <p>Please answer the question and list state(s), if applicable</p>	<p>Have you <u>ever</u> held, or do you currently hold, a license in another state? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If the answer to this question is <b>“yes”</b>, enter <u>all other state licenses</u> in Question 10 (below) and you must also request a License Verification from each state, in which you hold or have held a license.</p>
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<p><b>10. Licensure</b></p> <p>List all states or countries in which you are now, or ever have been licensed to practice your profession*.</p>	<table style="width:100%;"> <tr> <td style="width:50%;">State/Country:</td> <td style="width:50%;">State/Country:</td> </tr> <tr> <td>_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td>_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td>_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td>_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> </table>	State/Country:	State/Country:	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive
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_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive								

<p><b>11. Criminal Convictions</b></p> <p>Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.</p> <p>If necessary, you may continue on a separate 8½ x 11 sheet of paper.</p>	<p>Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):</p> <table style="width:100%;"> <tr> <td style="width:70%; border-bottom: 1px solid black;"></td> <td style="width:10%; text-align: center;">Month</td> <td style="width:20%; text-align: center;">Year</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"><input type="text"/></td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"><input type="text"/></td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"><input type="text"/></td> <td style="text-align: center;"><input type="text"/></td> </tr> </table>		Month	Year		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
	Month	Year											
	<input type="text"/>	<input type="text"/>											
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<p><b>12. Disciplinary Questions</b></p> <p>Check either Yes or No for each question.</p>	<p>1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <hr style="border-top: 1px dashed black;"/> <p>2. Have you ever been denied a license, certificate, registration or permit in any state? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>Note:</b> If you answer “Yes” to any question, you are <b>required</b> to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.</p>
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**13. Affidavit of Applicant**

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Licensed Dietitian/Nutritionist in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Dietetics Practice of any change in the answers to these questions after this application and this affidavit is signed.

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

\_\_\_\_\_  
Date of Signature (MM/DD/YY)



Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license. Copy this form as needed.

### Rhode Island Board of Dietetics Practice

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for a license to practice as a Dietitian/Nutritionist or Graduate Dietitian/Nutritionist in the State of Rhode Island. The Rhode Island Board of Dietetics Practice requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Dietetics Practice at the above address.

Print/Type Full Name _____	Signature _____	Date _____
Previous Names Used _____	Social Security Number _____	Date of Birth _____
License Number _____	Date Issued _____	

### THIS SECTION TO BE COMPLETED BY THE DIETETICS BOARD

**Directions for State Board:** Please complete and return this form to the address above with copies of any verification of supervision received\* after the applicant received their appropriate degree. *Please verify requirements met in your state:*

Degree from an Accredited School? <input type="checkbox"/> Yes <input type="checkbox"/> No	Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Explain)
Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No Score _____ Level of Exam: _____	License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued: _____ Expiration Date: _____

**Questions:**

- Has this licensee ever been investigated by your Board?  Yes  No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

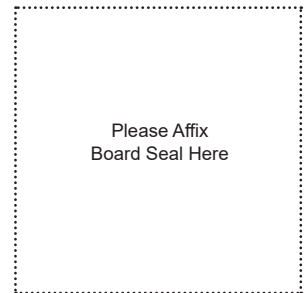
### Certification:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_

Full Name of Licensing Board \_\_\_\_\_



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*