

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

**Lactation Counselor Checklist**

- Application
- Application Fee
- ALC/CLC Certificate
- Proof of Age/Photo Identification
- O/S License Verification



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

Application Approved:

License Number:

Issue Date:

ID#:

Receipt #:

**Rhode Island**  
**Licensing of Lactation Consultants and Counselors**

Room 104  
 3 Capitol Hill  
 Providence, RI 02908-5097

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

FOR OFFICE USE ONLY

License #

Name

- Advanced Lactation Consultant (ALC)**
- Certified Lactation Counselor (CLC)**

**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

LAST NAME

FIRST NAME

MI

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 **\$50.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Lactation Counselors licenses expire on the 31st of January in each odd-numbered year.
- Proof of Age - Copy of your driver's license or other state issued ID verifying you are 18 years of age or older.
- Active Certification sent directly from the Academy of Lactation Policy and Practice (ALPP).
- 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 you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

### 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 Lactation Counselor

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.

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

First Name

Middle Name

Surname, (Last Name)

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

Maiden, 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.

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

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Home Phone

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

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Business Phone

Extension

Business Fax

7. Preferred Mailing Address

Please check ONE

- Please use my Home Address as my preferred mailing address
Please use my Business Address as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Form with grid boxes for Type of School, Name of School, Date Graduated (Month/Year), and Degree Received.

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state as a Lactation Counselor? Yes No

If the answer to this question is "yes", enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

Form with columns for State/Country, Active, and Inactive checkboxes.

YOU must send an "Interstate Verification Form" enclosed with this application to each state in which you are, or ever have been, licensed/certified as a Lactation Counselor (Make copies as needed).

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 x 11 sheet of paper.

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? Yes No

Abbreviation of State and Conviction1 (e.g. CA - Illegal Possession of a Controlled Substance):

Form with grid boxes for listing convictions, including Month and Year.

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? Yes No

2. Have you ever been denied a license, certificate, registration or permit in any state? Yes No

Note: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.

**13. Affidavit of Applicant**

Complete this section and sign.

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

I, \_\_\_\_\_, affirm that the information provided on my application form and documentation provided to support my application is true, accurate and unaltered. I acknowledge that pursuant to R.I.G.L. 11-18-1, knowingly making a false statement on my application form is punishable as a misdemeanor and that such an act shall constitute case for denial, suspension or revocation of my license/ permit to practice as a Lactation Counselor 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 Department of Health 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)



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

Substitute forms are not acceptable, copy this form as needed.

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSURE

I am applying for a license to practice as a Lactation Counselor in the State of Rhode Island. The Rhode Island Department of Health 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 Department of Health 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 LACTATION CONSULTANTS BOARD

Academic and Practical Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:
<p><b>Questions:</b></p> <p>1. Has this licensee ever been investigated by your Board? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>4. Do you know of any information that may discredit this person? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>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.).</p> <p>_____</p> <p>_____</p> <p>_____</p>		

### Certification:

_____ Signature	_____ Date
_____ Type or Print Name	
_____ Title	
_____ Full Name and State 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.*