

# INSTRUCTION SHEET

## Licensed Dietitian Nutritionist

- Examination  
Acceptance of Examination  
Endorsement  
Restoration

Please submit a completed and signed application, supporting documents, and fee to Illinois Department of Financial and Professional Regulation, PO Box 7007, Springfield, IL 62791. Alternatively, your fee may be submitted online using ePAY. IDFPR | Online Payments for Paper Applications ([illinois.gov](http://illinois.gov)).

Part I: Application Category Information – Complete as follows:

| Profession Name:                | Profession Code: | Licensure Method:                         | Fee:   |
|---------------------------------|------------------|---|--|
| Licensed Dietitian Nutritionist | 164              | Examination<br>Endorsement<br>Restoration | Exam - See Reference Sheet<br>Acceptance of Exam - \$100.00<br>Endorsement - \$100.00<br>Restoration – See RS form |

Parts II, III, IV, V:

Provide all information requested. Your Social Security Number (SSN) or an Individual Taxpayer Identification Number (ITIN) is mandatory. If you have neither an SSN or an ITIN, you must submit a Social Security Affidavit form available here:

(<https://idfpr.illinois.gov/content/dam/soi/en/web/idfpr/forms/online/SSNAffidavit.pdf>)

Part VI: You must answer each question. An affirmative response to any of the questions requires a detailed, personal statement and documentation.

Part VII: Examination applicants only - refer to the Reference Sheet.

Part VIII: Both questions must be answered.

Part IX: Application must be signed in ink and dated.

## GENERAL INFORMATION

**Documents in a Foreign Language:** All documents in a foreign language must be accompanied by an original, notarized translation that has been transcribed by a person other than the applicant, who is fluent in both English and the document language. The translator shall certify to the above requirements as well as to the accuracy of the translation.

**License Renewal:** All Dietitian Nutritionist licenses expire on October 31 of every odd-number year, regardless of the date of issuance.

**Three-Year Life of Application:** You have three years from the date your application is received by the Department or Continental Testing Service, Inc. to complete the application process. If the process is not completed in three years, your application will be denied and the fee forfeited. **Application fees are non-refundable.**

**Name Change:** If the name shown on your application is different than that shown on any documentation, you must submit proof of a legal name change such as a marriage license, divorce decree, or court order.

**Contact Information:** If assistance is needed, first review the information provided on the Dietitian Nutritionist page (<https://idfpr.illinois.gov/profs/dietnutrition.html>). You may also call 1-800-560-6420 or TTY 1-866-325-4949.

Additional application forms can be downloaded from the IDFPR Web site at [www.idfpr.illinois.gov](http://www.idfpr.illinois.gov)

## Education

### **Dietitian Nutritionists Educated Inside the United States**

Applicants must provide certification of education and an official transcript indicating a baccalaureate degree or post-baccalaureate degree in human nutrition, foods and nutrition, dietetics, food systems management, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, or nutrition and integrated health from a school or program accredited by an accrediting agency recognized by the Council on Higher Education Accreditation (CHEA) and the U.S. Department of Education; OR

### **Dietitian Nutritionists Educated Outside the United States or One of its Territories**

Applicant must provide certification of education and official transcript indicating a baccalaureate degree or post baccalaureate degree in an equivalent major course of study as determined by the Board and approved by the Department in accordance with the Dietitian Nutritionist Practice Act.

NOTE: An equivalent major course of study must include specific coursework in clinical life science and nutrition and/or metabolism as outlined in Section 1245.130 of the Administrative Rules.

## Experience

Nine hundred (900) hours of experience in dietetics or nutrition must be completed in the United States within a five year time frame. The experience must be received from a supervisor who, at the time direct supervision took place, has at least three years of experience in dietetics and nutrition and is one of the following:

1. An individual who holds an active license in Illinois or an actively licensed resident of another jurisdiction if the jurisdiction in which the supervisor practices requires licensure;
2. A licensed practitioner (such as a licensed physician or registered nurse) whose license includes nutrition care;
3. An individual with a doctoral degree conferred by a US regionally accredited college or university with a major course of study in human nutrition, nutrition education, food and nutrition, dietetics or food systems management, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, or nutrition and integrative health;
4. A registered dietitian or registered dietitian nutritionist of the Commission on Dietetic Registration;
5. A certified clinical nutritionist of the Clinical Nutrition Certification Board;
6. A certified nutrition specialist of the Board of Certification of Nutritionist Specialists;
7. A diplomate of the Academy of Nutrition and Dietetics; or
8. A supervisor approved by the Department.

The supervisor shall observe, supervise, and assess the applicant through contact or meetings with the supervisee. The practice experience may be obtained concurrently with or following the completion of the education requirements. Internships approved by the following meet the experience requirements:

1. Accreditation Council for Education in Nutrition and Dietetics;
2. American Clinical Board of Nutrition;
3. Board for Certification of Nutrition Specialists; and
4. Clinical Nutrition Certification Board.

## Application for Examination

### Supporting Documentation

To apply to take the examination for licensure as a Dietitian Nutritionist, the following Supporting Documents must be submitted with the 4-page Application for Licensure and/or Examination:

Application for Licensure by Examination is a dual application process. Your application for examination will be evaluated by the Department of Financial and Professional Regulation to determine your eligibility for examination. If it is determined that you are eligible for examination, included in the Department's notification will be an examination registration form, and further instructions.

1. **CT (Certification of Licensure)**--If you have ever held a license as a dietitian/nutritionist in another jurisdiction, this document must be completed by the jurisdiction of original licensure and the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary.
2. **ED (Certification of Education)**--This document must be completed in its entirety by an official of the college or university from which your degree was received and must have school seal affixed.
3. Submit an official transcript from a baccalaureate or post baccalaureate program in an acceptable major course of study with school seal affixed.
4. **Licensed Dietitian Nutritionist Academic Criteria**--This document must be completed if you are applying on the basis of similar degree program. Include copies of course descriptions for each course.
5. **Dietitian Nutritionist Educated Outside the United States or one of its Territories**--You must have your education credentials evaluated by an accrediting agency approved by the U.S. Department of Education as offering a degree equivalent to the baccalaureate or post-baccalaureate degree conferred by a regionally accredited college or university in the United States.
6. **VE-DNU (Verification of Employment/Experience)**--This document must be used for supervised experience earned after July 1, 1995 and must show verification of at least 900 hours of supervised experience as defined on page 2 of this application.

**~Note~**

*Applicants who fail the examination three times shall be required to submit proof to the Department of the completion of 6 semester hours of dietetic and nutrition course work as defined in the Rules.*

## Acceptance of Examination

### Supporting Documentation

To apply for licensure on the basis of Acceptance of Examination, the following supporting documents must be submitted with the 4-page Application for Licensure and/or Examination:

1. **CT (Certification of Licensure)**--If you have ever held a license as a dietitian nutritionist in another state or territory of the United States or in a foreign country, this document must be completed by the jurisdiction of original licensure and the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary.
2. **ED (Certification of Education)**--This document must be completed in its entirety by an official of the college or university from which your degree was received and must have school seal affixed.
3. Submit an official transcript from a baccalaureate or post-baccalaureate program in an acceptable major course of study as outlined in Section 1245.130 of the Rules with school seal affixed.
4. **Licensed Dietitian Nutritionist Academic Criteria**--This document must be completed if you are applying on the basis of a similar degree program. Include copies of course descriptions for each course.
5. **Dietitian Nutritionists Educated Outside the United States or one of its Territories**--You must have your education credentials evaluated by an accrediting agency approved by the U.S. Department of Education as offering a degree equivalent to the baccalaureate or post-baccalaureate degree conferred by a regionally accredited college or university in the United States.
6. **VE-DNU (Verification of Employment/Experience)**--This document must show verification of at least 900 hours of supervised experience or an internship as defined on page 2 of this application.  
  
For experience earned after July 1, 1996, supervisor(s) must submit a vitae in order to verify 3 years of employment in dietetics.
7. Proof of passage of the examination given through the Commission on Dietetic Registration; the American Clinical Board of Nutrition; the Board for Certification of Nutrition Specialists; and the Clinical Nutrition Certification Board during the last 12 months. (This applies to individuals who are not "Registered Dietitians" with CDR.)
8. ***In lieu of the documents listed in 2 through 7 above, applicant may submit a copy of current registration or certification as one of the following:***
  - Certified Clinical Nutritionist;
  - Certified Nutrition Specialist;
  - Diplomate of the American Clinical Board of Nutrition; or
  - Registered Dietician or Registered Dietician nutritionist

## Endorsement of Licensure

### Supporting Documentation

To apply for licensure on the basis of Endorsement of Licensure in another state, the following supporting documents must be submitted with the 4-page Application for Licensure and/or Examination:

1. **CT (Certification of Licensure)**--This document must be completed by the jurisdiction of original licensure and the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary.
2. **ED (Certification of Education)**--This document must be completed in its entirety by an official of the college or university from which your degree was received and must have school seal affixed.
3. Submit an official transcript from a baccalaureate or post-baccalaureate program in an acceptable major course of study as outlined in Section 1245.130 of the Rules with school seal affixed.
4. **Licensed Dietitian Nutritionist Academic Criteria**--This document must be completed if you are applying on the basis of a similar degree program. Include copies of course descriptions for each course.
5. **Dietitian Nutritionists Educated Outside the United States or one of its Territories**--You must have your education credentials evaluated by an accrediting agency approved by the U.S. Department of Education as offering a degree equivalent to the baccalaureate or post-baccalaureate degree conferred by a regionally accredited college or university in the United States.
6. **VE-DNU (Verification of Employment/Experience)**--This document must show verification of at least 900 hours of supervised experience or an internship as defined on page 3 of this application.
7. Proof of passage of the examination given through the Commission on Dietetic Registration.
8. ***In lieu of the documents listed in 2 through 7 above, applicant may submit a copy of current registration or certification as one of the following:***
  - Certified Clinical Nutritionist;
  - Certified Nutrition Specialist;
  - Diplomate of the American Clinical Board of Nutrition; or
  - Registered Dietician or Registered Dietician nutritionist

# RESTORATION

## Supporting Documentation

### ~IMPORTANT NOTICE~

These Restoration Instructions apply only to those individuals whose licenses have been on inactive status, or in non-renewed status, for five or more years.

**If your license has been inactive or in non-renewed status for less than five years you should contact the Department of Financial and Professional Regulation at 1-800-560-6420 for detailed instructions on how to restore it to active status.**

### ~For Assistance~

*Call the Department of Financial and Professional Regulation at one of the following numbers and state that you are applying to become licensed as a Licensed Dietitian Nutritionist and need help with your application:*

**1-800-560-6420  
TTY - 1-866-325-4949**

To restore your Illinois Dietitian Nutrition Counselor or Dietitian Nutritionist license which has been expired for more than five years, the following supporting documents must be submitted with the 4-page Application for Licensure and/or Examination:

1. **RS (Restoration of Licensure)**--This document must be completed. If this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 1-800-560-6420.
2. **VE (Verification of Employment/Experience)**--If you are currently licensed and actively practicing in another state or territory of the U.S., you must have this document completed by your employer. If self-employed, complete this document on your own behalf. (If this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 1-800-560-6420.)
3. **VE (Verification of Employment/Experience)**--If you are restoring based upon experience other than active practice in another state or territory (i.e., research, teaching, or publishing) this document must be completed on your behalf by your employer. If self-employed, complete this document on your behalf. (If this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 1-800-560-6420.)
4. **Continuing Education Verification**--All applicants for restoration **MUST** submit verification of completion of 30 hours of continuing education obtained within the 24 months immediately preceding submission of your application for restoration. Verification must be in the form of a certificate(s) of attendance issued by the sponsor of the continuing education program(s).
5. **Military Service**--If restoring your license after active military service, submit a copy of military form DD214.
6. **CT (Certification of Licensure)**--This document must be completed by the jurisdiction(s) where you have most recently been practicing, if applicable. You are authorized to photocopy the form if necessary.  
**OR**
7. **Passage of Examination**--Submit proof of passage of the CDR examination for dietitian nutritionists during the period the license was lapsed or on inactive status;  
**OR**

Submit proof of current status as a registered dietitian or registered dietitian nutritionist, certified clinical nutritionist, certified nutrition specialist, or Diplomate of the American Clinical Board of Nutrition from the Commission on Dietetic Registration.

## LICENSURE METHODS AND DEFINITIONS

*Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.*

### Licensure Methods

### Definition

Examination

Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department.

Endorsement of License

Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued.

Acceptance of Examination

Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.

Restoration

Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review.

Grandfather/Waiver

Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).

Non-examination

Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.

# IMPORTANT NOTICE

## Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966.**"

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"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse.**"



## REFERENCE SHEET - A

### ALL FEES ARE NONREFUNDABLE

Department reserves the right to change examination dates, filing deadlines, and fees if prevailing circumstances necessitate such action.

#### CHART I - PROFESSION NAME, PROFESSION CODE, LICENSURE METHOD & FEE

| <u>PROFESSION NAME</u>          | <u>PROFESSION CODE</u> | <u>LICENSURE METHOD</u> | <u>APPLICATION FEE</u>     |
|---------------------------------|------------------------|-------------------------|----------------------------|
| Licensed Dietitian Nutritionist | 164                    | Examination             | \$100.00                   |
| Licensed Dietitian Nutritionist | 164                    | Acceptance of Exam      | \$100.00                   |
| Licensed Dietitian Nutritionist | 164                    | Endorsement             | \$100.00                   |
| Licensed Dietitian Nutritionist | 164                    | Restoration             | See Supporting Document RS |

#### CHART II - EXAMINATION CODES AND FEES

**NOTE:** SINCE THE APPLICATION FOR EXAMINATION IS A DUAL APPLICATION PROCESS, THIS INFORMATION WILL ONLY BE PROVIDED UPON APPROVAL OF YOUR APPLICATION FOR EXAMINATION. ONCE THE APPLICATION HAS BEEN APPROVED, AN EXAMINATION PACKAGE WILL BE FORWARDED TO YOU. AN EXAMINATION FEE WILL BE REQUIRED WHEN REGISTERING FOR AN EXAMINATION.

#### CHART III - EXAMINATION DATES

INFORMATION WILL BE AVAILABLE ONCE YOU ARE APPROVED FOR THE EXAMINATION.

#### CHART IV - SCHOOL CODES

NOT APPLICABLE FOR LICENSED DIETITIAN NUTRITIONIST  
ENTER N/A IN PART VII c) OF APPLICATION  
FOR LICENSURE AND/OR EXAMINATION

#### REQUEST FOR ASSISTANCE

If assistance is needed, direct your request to one of the following telephone numbers:

Licensure Methods **Except** Examination (**US ONLY**)

1-800-560-6420

TTY

1-866-325-4949

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

Examination Licensure Method **Only**

708/354-9911

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Dietitian Nutritionist

Before you mail your application, check the following items to make sure your application is complete!

| FOUR-PAGE APPLICATION REVIEW  | COMPLETED |
|---|-----------|
| Part I. Application Category Information  |           |
| Part II. Applicant Identifying Information  |           |
| Part III. Education Information   |           |
| Part IV. Record of Licensure Information  |           |
| Part V. Record of Examination   |           |
| Part VI. Personal History Information   |           |
| Part VII. Examination Coding Information (if applicable)  |           |
| Part VIII. Child Support and/or Student Loan Information  |           |
| Part IX. Certifying Statement--Signed and Dated   |           |
| SUPPORTING DOCUMENTS  | SUBMITTED |
| ED Form (if applicable)   |           |
| <b>Current copy of Registration Card</b> (if applicable)  |           |
| VE-DNU Form (if applicable)   |           |
| VE Form (if applicable)   |           |
| <b>Academic Criteria Form</b> (if applicable)   |           |
| CT Form from <b>original</b> state of licensure and <b>current</b> state of licensure (if applicable) |           |
| RS Form, if applicable ( <b>NOTE:</b> if restoring)   |           |
| <b>Proof of 30 hours of Approved Continuing Education</b> (if applicable)                             |           |
| Copy of <b>DD214</b> if restoring from active military service  |           |

**All supporting documents may not be required. Please refer to application instructions for your specific method of licensure.**

# APPLICATION FOR LICENSURE AND/OR EXAMINATION

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is **VOLUNTARY**. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. **FEES ARE NOT REFUNDABLE.**
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

## PART I: Application Category Information

A. Check the box indicating the appropriate information regarding your application.  Military  Military Spouse  Not Military  Decline to Answer

Military service member is defined as. "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

|                    |                    |                     |        |
|--------------------|--------------------|---------------------|--------|
| 1. PROFESSION NAME | 2. PROFESSION CODE | 3. LICENSURE METHOD | 4. FEE |
|                    | _ _ _              |                     | \$     |

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- |  |   |
|--|---|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.   | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements. |
| <input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.               |
| <input type="checkbox"/> Other: _____  |   |

## PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

|   |                                     |  |
|---|-------------------------------------|--|
| 1. NAME LAST FIRST MIDDLE   | 2. TITLE (e.g., M.D., D.D.S., etc.) | 3. SSN OR ITIN   |
|   |                                     | _ _ _ - _ _ - _ _  |
| 4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY  |                                     | ZIP CODE COUNTY  |
|   |                                     | _ _ _ - _ _ - _ _  |
| 5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY   |                                     | ZIP CODE COUNTY  |
|   |                                     | _ _ _ - _ _ - _ _  |
| 6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED.<br>(SEE INSTRUCTIONS #5 ABOVE) |                                     |  |
| 7. PLACE OF BIRTH CITY STATE/COUNTRY  |                                     | 8. DATE OF BIRTH   |
|   |                                     | _ / _ / _  |
|   |                                     | Month Day Year   |
|   |                                     | 9. AGE <input type="checkbox"/> Female <input type="checkbox"/> Male                         |
| 10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED   |                                     |  |
| Work: ( _ _ _ ) _ _ - _ _ _ _ Home: ( _ _ _ ) _ _ - _ _ _ _   |                                     |  |
| (Area Code) (Area Code)   |                                     |  |
| 11. EMAIL ADDRESS (REQUIRED)  |                                     | 12. I CONSENT TO PROFESSIONAL ORGANIZATIONS HAVING MY EMAIL ADDRESS <input type="checkbox"/> |

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

**PART III: Education Information**

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)  
**1 2 3 4 5 6 7 8 9 10 11 12**      Graduated High School?  Yes  No      Received OR G.E.D.?  Yes  No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED      3. LAST PRELIMINARY SCHOOL LOCATION (City and State)      4. DATE OF GRADUATION  
 \_\_\_\_\_ / \_\_\_\_\_  
 Month      Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)  
**1 2 3 4 5 6 7 8**      Graduated?  Yes  No

| 6. COLLEGE OR UNIVERSITY NAME<br>(Undergraduate and Graduate) | LOCATION<br>(City and State or Country) | DATES OF ATTENDANCE |            | TYPE OF DEGREE EARNED |
|---|---|---------------------|------------|-----------------------|
|   |   | FROM                | TO         |                       |
|   |   | Month/Year          | Month/Year |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |
|   |   |                     |            |                       |

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

| INSTITUTION NAME | LOCATION<br>(City and State or Country) | DATES OF ATTENDANCE |            | Did You Complete Training?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|------------------|---|---------------------|------------|--|
|                  |   | FROM                | TO         |  |
|                  |   | Month/Year          | Month/Year | <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"/> Yes <input type="checkbox"/> No                               |
|                  |   |                     |            | <input type="checkbox"/> Yes <input type="checkbox"/> No                               |

**PART IV: Record of Licensure Information**

*If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.*

| STATE  | PROFESSION NAME | LICENSE NUMBER | DATE OF ISSUANCE | LICENSE STATUS (Active, Lapsed, etc.) |
|--|-----------------|----------------|------------------|---------------------------------------|
| State of Original Licensure  |                 |                |                  |                                       |
| State of Current Licensure where you most recently have been practicing. |                 |                |                  |                                       |
| Other States of Licensure  |                 |                |                  |                                       |
|  |                 |                |                  |                                       |
|  |                 |                |                  |                                       |
|  |                 |                |                  |                                       |
|  |                 |                |                  |                                       |
|  |                 |                |                  |                                       |

*(If additional space is needed, attach a separate sheet.)*

**PART V: Record of Examination**

*If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.*

| NAME OF EXAMINATION | STATE | MONTH/YEAR | EXAM RESULTS             |
|---------------------|-------|------------|--------------------------|
|                     |       |            | (Passed, Failed, Absent) |
|                     |       |            |                          |
|                     |       |            |                          |
|                     |       |            |                          |
|                     |       |            |                          |
|                     |       |            |                          |

*(If additional space is needed, attach a separate sheet.)*

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

**PART VI: Personal History Information (This part must be completed by all applicants)**

YES NO

1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*

**PART VII: Examination Coding Information (This part is for examination applicants only)**

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

|                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

b) CHART III - Select the examination site you desire and enter Test Center Code:

|                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

c) CHART IV - Find your School of Graduation and enter school code:

|                      |
|----------------------|
| <input type="text"/> |
|----------------------|

d) Record the number of times you have taken this exam in Illinois or any other state:

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

**PART VIII: Child Support, Tax Information and Workers' Compensation (Every applicant is required by law to respond to the following questions)**

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**  
Are you more than 30 days delinquent in complying with a child support order? Yes  No   
*(NOTE: If you are not subject to a child support order, answer "no.")*
2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."  
Are you delinquent in the filing of state taxes? Yes  No
3. In accordance with 20 ILCS 2105/2105-15(g-5), "The Department shall refuse the issuance or renewal of a license to, or suspend or revoke the license of, any individual, corporation, partnership, or other business entity that has been found by the Illinois Workers' Compensation Commission or the Department of Insurance to have failed to secure workers' compensation obligations, or pay in full a fine or penalty imposed due to a failure to secure workers' compensation obligations."  
Are you delinquent in complying with workers' compensation obligations? Yes  No
4. Do you certify you have fully complied with this profession's continuing education requirements? Yes  No   
*NOTE: Continuing education is not required for the first renewal of this license. If this is your first renewal, please answer (Yes) to this question. Making a false statement may subject the licensee to disciplinary action. You may verify the continuing education requirements of your profession here: <https://idfpr.illinois.gov/rules2015.html>*

**PART IX: Method of Payment and Certifying Statement**

Check / Money Order. Check Number: \_\_\_\_\_

Online. Paid Online at: <https://idfpr.illinois.gov/epay.html> in the amount of \_\_\_\_\_. Approved #: \_\_\_\_\_

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete. **I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.**

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

\_\_\_\_\_  
Date

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

## CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

# CT

**FOR EXAM USE ONLY**

**APPLICANT:** Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

|   |   |  |
|---|---|--|
| 1. NAME      LAST              FIRST              MIDDLE<br><br>  | 2. DATE OF BIRTH<br>____ / ____ / ____<br><small>Month      Day      Year</small>   | 3. SSN OR ITIN<br>____ - ____ - ____         |
| 4. ADDRESS    STREET, CITY, STATE, ZIP CODE<br><br>   | 5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.<br><br><div style="display: flex; justify-content: space-between;"> <span>_____ Profession Name</span> <span>_____ Profession Code</span> </div> |  |
| 6. MAIDEN OR GIVEN SURNAME<br><br>  | 7. APPLICANT TELEPHONE NUMBER (Daytime)<br>Area Code ( ____ ) _____ - _____   |  |
| 8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable) | 8b. LICENSE NUMBER (If applicable)  | 8c. ISSUANCE DATE OF LICENSE (If applicable) |

I hereby authorize \_\_\_\_\_ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.  
Name of Licensing Agency or Board

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

### RETURN COMPLETED FORM TO APPLICANT

**LICENSING AGENCY:** The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

**PART I - CERTIFICATION OF EXAMINATION STATUS**

A. The applicant  has written  is scheduled to write the following examination:  
 \_\_\_\_\_  
Name of Examination Date of Examination

B. The applicant has or will have written the above-named examination \_\_\_\_\_ number of times.

**PART II - CERTIFICATION OF LICENSURE**

|  |                               |
|--|-------------------------------|
| A. NAME OF PROFESSION AS IT APPEARS ON LICENSE   | B. LICENSE NUMBER             |
| C. ISSUANCE DATE OF LICENSE  | D. EXPIRATION DATE OF LICENSE |
| E. LICENSURE METHOD<br><input type="checkbox"/> Examination (Administered in Your State)<br><input type="checkbox"/> National (Name) _____<br><input type="checkbox"/> State Constructed _____<br><input type="checkbox"/> Other (Name) _____<br><input type="checkbox"/> Endorsement of License (State) _____<br>Acceptance of Examination Results _____<br>(Administered in Another State) _____ |                               |

Reciprocity with (State) \_\_\_\_\_  
 Waiver/Grandfather \_\_\_\_\_  
 Credentials \_\_\_\_\_  
 Other (Describe) \_\_\_\_\_

|  |   |
|--|---|
| F. CURRENT LICENSURE STATUS<br><input type="checkbox"/> Active<br><input type="checkbox"/> Inactive<br><input type="checkbox"/> Lapsed<br><input type="checkbox"/> Other (Explain) _____<br>_____<br>_____ | G. IF LICENSED BY EXAMINATION, RECORD SCORES<br>Type of Examination                      Score<br>Written                                      _____<br>Practical                                      _____<br>Other (Describe) _____<br>_____<br>Received no Grade Below _____<br>Examination Period ____ days ____ hours |
|--|---|

**PART III - CERTIFICATION OF EXAMINATION SCORES**

A1. National or other Profession Specific Examination  
(Record all available information)

Date of Examination \_\_\_\_\_

|                    |       |                 |       |
|--------------------|-------|-----------------|-------|
| Scaled Score       | _____ | Raw Score       | _____ |
| Standard Deviation | _____ | Corrected Score | _____ |
| National Mean      | _____ | Percent Score   | _____ |

A 2

| SUBJECT | DATE | SCORE | SUBJECT | DATE | SCORE |
|---------|------|-------|---------|------|-------|
|         |      |       |         |      |       |
|         |      |       |         |      |       |
|         |      |       |         |      |       |
|         |      |       |         |      |       |
|         |      |       |         |      |       |

B. State Constructed Examination

| SUBJECT | DATE | SCORE | SUBJECT | DATE | SCORE |
|---------|------|-------|---------|------|-------|
|         |      |       |         |      |       |
|         |      |       |         |      |       |
|         |      |       |         |      |       |
|         |      |       |         |      |       |
|         |      |       |         |      |       |

**PART IV - FORMAL ACTIONS**

- A. Is there now or has there ever been any formal action commenced against the applicant?  Yes  No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.)  Yes  No

**PART V - RECIPROCAL REGISTRATION**

This state  does  does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

SEAL

\_\_\_\_\_

Print Name

\_\_\_\_\_

Title

\_\_\_\_\_

Agency/Board Street Address

\_\_\_\_\_

City, State, ZIP Code

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

Area Code (      )

\_\_\_\_\_

Telephone Number

**ATTENTION APPLICANT--RETURN EXAM CT TO:** Continental Testing Services, Inc.  
P.O. Box 100  
LaGrange, Illinois 60525-0100



**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

## CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

# ED

FOR CTS EXAM USE ONLY

**APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.**

|   |   |                                      |
|---|---|--------------------------------------|
| 1. NAME<br>LAST FIRST MIDDLE                | 2. DATE OF BIRTH<br>____/____/____<br>Month Day Year  | 3. SSN OR ITIN<br>____ - ____ - ____ |
| 4. ADDRESS<br>STREET, CITY, STATE, ZIP CODE | 5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.<br><br>_____<br>Profession Name                      Profession Code |                                      |
| 6. MAIDEN OR GIVEN SURNAME                  |   |                                      |
| 7. NAME OF INSTITUTION ATTENDED             | 8. DATE OF GRADUATION / COMPLETION<br>____/____/____<br>Month Day Year  |                                      |

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

\_\_\_\_\_ Date

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

**SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side.**

|  |   |
|--|---|
| A. NAME OF INSTITUTION   | B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE   |
| C. DEPARTMENT OF INSTITUTION   | D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT  |
| E. MAJOR AREA OF STUDY OF THE APPLICANT  | F. APPLICANT WAS (CHECK ONE):<br><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Co-op |
| G. CREDIT HOURS EARNED<br>(CHECK ONE AND COMPLETE)<br><input type="checkbox"/> _____ Semester Hours<br><input type="checkbox"/> _____ Quarter Hours<br><input type="checkbox"/> _____ Course Hours   | H. DATES OF ATTENDANCE<br>From ____/____/____ To ____/____/____<br>Month Day Year                      Month Day Year                 |
| I. Total academic years attended _____<br><b>OR</b> Years Months Days<br>Total calendar years attended _____<br>Years Months Days  | J. TYPE OF DEGREE OR CERTIFICATE AWARDED<br>(e.g., B.A., M.A., M.D., Ph.D.)   |
| K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET<br>____/____/____<br>Month Day Year   | L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED<br>____/____/____<br>Month Day Year  |
| M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE<br><input type="checkbox"/> Applicant has graduated on ____/____/____<br>Month Day Year <input type="checkbox"/> Applicant has completed program on ____/____/____<br>Month Day Year<br><input type="checkbox"/> Applicant will graduate on ____/____/____<br>Month Day Year <input type="checkbox"/> Applicant will complete program on ____/____/____<br>Month Day Year |   |
| N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:   |   |

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

Large empty rectangular box for recording additional information.

I certify that the information recorded herein is true and correct according to the official records of this institution.

\_\_\_\_\_
Print Name of School Official

\_\_\_\_\_
Signature of School Official

\_\_\_\_\_
Title

\_\_\_\_\_
Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_
Date of Expiration

\_\_\_\_\_
Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

Large empty rectangular box at the bottom of the page.

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 ILCS 30/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**VERIFICATION OF  
EMPLOYMENT/EXPERIENCE**

SUPPORTING DOCUMENT

**VE-DNU**

**APPLICATION: Complete the applicant section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.**

|  |  |                                      |
|--|--|--------------------------------------|
| 1. NAME<br>LAST FIRST MIDDLE             | 2. DATE OF BIRTH<br>____ / ____ / ____<br>Month Day Year   | 3. SSN OR ITIN<br>____ - ____ - ____ |
| 4. ADDRESS STREET, CITY, STATE, ZIP CODE | 5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. |                                      |
| 6. MAIDEN OR GIVEN SURNAME               | _____<br>Profession Name   | _____<br>Profession Code             |

COMPLETE BOXES 7, 8, 9 AND 10 TO REFLECT INFORMATION AT TIME OF EMPLOYMENT/EXPERIENCE

|                     |   |
|---------------------|---|
| 7. SUPERVISOR NAME  | 8. BUSINESS/INSTITUTION NAME              |
| 9. SUPERVISOR TITLE | 10. ADDRESS STREET, CITY, STATE, ZIP CODE |

**SUPERVISOR: Complete the remainder of this form. RETURN THIS FORM DIRECTLY TO THE APPLICANT IN A SEALED ENVELOPE.**

*The experience must have been received from a supervisor who had at least 3 years of experience in dietetics and nutrition at the time of supervision.*

**PART I. - SUPERVISION INFORMATION**

|  |                              |
|--|------------------------------|
| A. IMMEDIATE/DIRECT SUPERVISOR'S NAME  | B. BUSINESS/INSTITUTION NAME |
| C. REGISTRATION NUMBER   | D. REGISTRATION STATE        |
| E. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE  |                              |
| F. BUSINESS TELEPHONE NUMBER<br>Area Code ( ____ ) ____ - ____   |                              |
| G. PROFESSIONAL DESIGNINATION  |                              |
| <input type="checkbox"/> Registered Dietitian or Dietitian Nutritionist <input type="checkbox"/> Registered Nurse<br><input type="checkbox"/> Licensed Physician/Surgeon <input type="checkbox"/> Diplomate of the Academy of Nutrition and Dietetics<br><input type="checkbox"/> Certified Clinical Nutritionist <input type="checkbox"/> Other: An individual with a doctoral degree with a major course of study in human nutrition, nutrition education, food and nutrition, public health, dietetics or food systems management.<br><input type="checkbox"/> Certified Nutrition Specialist |                              |

**PART II. - APPLICANT EMPLOYMENT INFORMATION**

|  |   |
|--|---|
| A. APPLICANT'S JOB TITLE AT TIME OF EMPLOYMENT/ EXPERIENCE | B. DATES OF APPLICANT'S EMPLOYMENT/EXPERIENCE<br>From ____ / ____ / ____ To ____ / ____ / ____<br>Month Day Year Month Day Year |
| C. NUMBER OF HOURS APPLICANT WORKED PER WEEK               | D. NUMBER OF HOURS YOU MET WITH THE APPLICANT PER WEEK  |

**PART II. - APPLICANT EMPLOYMENT INFORMATION (Continued)**

E. INDICATE YOUR OVERALL EVALUATION OF THE APPLICANT'S PERFORMANCE UNDER YOUR DIRECT SUPERVISION

|            |               |               |          |
|------------|---------------|---------------|----------|
| Circle One | Excellent     | Satisfactory  | Poor     |
|            | <b>5    4</b> | <b>3    2</b> | <b>1</b> |

F. COMMENTS ABOUT APPLICANT'S JOB PERFORMANCE:

G. INDICATE PERCENTAGE OF APPLICANT'S TIME SPENT IN THE FOLLOWING AREAS:

| <u>Service Area</u>   | <u>Percent of Time Worked</u> |                |
|---|-------------------------------|----------------|
|   | <u>Non-medical</u>            | <u>Medical</u> |
| Nutrition Assessment  | _____                         | _____          |
| Nutrition Ed/Counsel  | _____                         | _____          |
| Developing and Managing Systems whose<br>Chief Function is Nutrition Care | _____                         | _____          |
| *Other  | _____                         | _____          |

\*If Other is indicated, please explain.

The above indicated experience has been performed by the applicant pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

|       |           |
|-------|-----------|
| _____ | _____     |
| Date  | Signature |
| _____ | _____     |
|       | Title     |

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 ILCS 30/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

## DIETITIAN NUTRITIONIST ACADEMIC CRITERIA

**APPLICANT:** Complete a separate form for each institution in which you have completed graduate coursework. You may copy this form as needed.

|  |   |                             |
|--|---|-----------------------------|
| 1. NAME LAST FIRST MIDDLE                | 2. DATE OF BIRTH<br>____ / ____ / ____<br>Month Day Year  | 3. SSN OR ITIN<br>- - - - - |
| 4. ADDRESS STREET, CITY, STATE, ZIP CODE | 5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.<br><br><div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> <u>Dietitian Nutritionist</u><br/>           Profession Name         </div> <div style="text-align: center;"> <u>1 6 4</u><br/>           Profession Code         </div> </div> |                             |
| 6. MAIDEN OR GIVEN SURNAME               |   |                             |
| 7. NAME OF COLLEGE/INSTITUTION           | 8. DEPARTMENT   |                             |
| 9. ADDRESS OF COLLEGE/INSTITUTION        | 10. PROGRAM (AREA OF SPECIALIZATION AS IT APPEARS ON TRANSCRIPT.)   |                             |

### ACADEMIC CRITERIA

| COURSE WORK  | COURSE TITLE | COURSE NO. | YEAR | COMMENTS |
|--|--------------|------------|------|----------|
| <b>Clinical or Life Science - 18 Semester Hours, comprised of the following:</b>   |              |            |      |          |
| • Anatomy and/or physiology – 3 semester hours   |              |            |      |          |
| • Counseling and/or behavioral sciences – 3 semester hours   |              |            |      |          |
| • Other Clinical and/or Life Science courses – 12 hours, including medicine, organic chemistry, biology, microbiology, molecular biology, biotechnology, botany, nutrition science, neuroscience, environmental science, immunotherapy, pathology, research methods and applied statistics, biostatistics, epidemiology, genetics, genomics and/or pharmacology.   |              |            |      |          |
| <b>Nutrition and/or Metabolism – 18 Semester Hours, comprised of the following:</b>  |              |            |      |          |
| • Biochemistry – 6 semester hours  |              |            |      |          |
| • Other Nutrition and/or Metabolism courses – 12 hours, including micronutrients, macronutrients, vitamins and minerals, nutrition education, nutrition counseling, nutrition through the life cycle, endocrinology, therapeutic nutrition, nutritional aspects of disease, pathophysiologic basis of metabolic disease, functional medicine nutrition, molecular metabolism and/or developmental nutrition. |              |            |      |          |