



APPLICATION FOR INDIANA DIETITIAN LICENSURE

State Form 47586 (R9 / 1-21)

**MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

- INSTRUCTIONS:**
1. The fee for this application is \$20.00, payable to the Indiana Professional Licensing Agency, in accordance with 830 IAC 1-4-1.
 2. Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.
 3. All fees are non-refundable and non-transferable.
 4. Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.

NOTICE: Applications will not be reviewed until all required documents are received by the Board.

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.
*** Attach a copy of your registration card as provided by the Commission on Dietetic Registration.

FOR OFFICE USE ONLY		
Application fee	Date fee paid (month, day, year)	Receipt number
License number issued	Date license issued (month, day, year)	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION			
Name of applicant (last, first, middle)		Social Security number *	
Date of birth (month, day, year)	Gender ** <input type="checkbox"/> Male <input type="checkbox"/> Female	RD Registration number ***	
Address of applicant (number and street or rural route)		City, state, and ZIP code	
Telephone number (daytime) ()	E-mail address		
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: (Please select ONLY ONE of the following.) <input type="checkbox"/> I am a United States Citizen. <input type="checkbox"/> I am a qualified alien (as defined under 8 USC § 1641). <input type="checkbox"/> I am authorized by the Federal government to work in the United States.			
Are you the spouse of a member of the military who is assigned to a duty station in Indiana? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you an active duty member of the military? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No	

EDUCATION			
<i>List all colleges and universities attended. Official transcript(s) must be provided directly from each institution.</i>			
CERTIFICATE / DEGREE GRANTING INSTITUTION	CERTIFICATE / DEGREE GRADUATION DATE (month, year)	DATES ATTENDED	
		From (month, year)	To (month, year)

EXAMINATION INFORMATION	
Are you a Registered Dietitian (RD) with the Commission on Dietetic Registration (CDR)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Made application	<i>If No, complete the intern / experience form.</i>
Have you passed an examination offered by the Commission on Dietetic Registration (CDR) for licensure, certification or registration in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXPERIENCE

List all professional work experience during the five (5) year period immediately preceding the filing of this application. If necessary, attach extra sheets following the prescribed format. Please sign and date any extra sheets. For part-time employment, if less than forty (40) hours per week, list number of hours in space provided below.

Name of current employer	Job title	Period of employment From _____ To _____		
Address (number and street)	Number of years employed	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Number of hours employed	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
City, State, and ZIP code	Name of Supervisor			
Duties				

Name of employer	Job title	Period of employment From _____ To _____		
Address (number and street)	Number of years employed	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Number of hours employed	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
City, State, and ZIP code	Name of Supervisor			
Duties				

LICENSE INFORMATION

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

TYPE OF LICENSE	STATE	NUMBER	DATE ISSUED (month, year)	CURRENT STATUS

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice dietetics or any other regulated health occupation in any state (including Indiana) or country?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,		
(1) have you ever been arrested;	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(5) have you ever pled <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restriction, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant

Date (*month, day, year*)