Reset Form

APPLICATION FOR INDIANA DIETITIAN LICENSURE

State Form 47586 (R8 / 7-19)

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.

FOR OFFICE USE ONLY	
DATE OF RECEIPT (*month, day, year*)	
RECEIPT NUMBER	
AMOUNT PAID	
LICENSE NUMBER	
LICENSE ISSUANCE DATE (*month, day, year*)	

APPLICANT
Attach one (1) passport type quality photograph of yourself taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	RD Registration number ***
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

**** Attach a copy of your registration card as provided by the Commission on Dietetic Registration.*

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No

Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

EDUCATION

List all colleges and universities attended. Attach official or notarized transcript(s) from all degree granting colleges or universities.

CERTIFICATE / DEGREE GRANTING INSTITUTION	CITY	STATE	MAJOR	CERTIFICATE / DEGREE GRADUATION DATE *(month, year)*	DATES ATTENDED From *(month, year)*	DATES ATTENDED To *(month, year)*

PRE-PROFESSIONAL EXPERIENCE

Indicate the type of experience you have completed *(check only one box)*
☐ Dietetic internship accredited by the Commission on Dietetic Registration (CDR)
☐ Coordinated program in Dietetics accredited by CDR
☐ Pre-Professional Practice programs approved by CDR
☐ Other *(specify)* _____

Indicate place(s) and dates of experience checked above.

DATES ATTENDED From *(month, year)*	DATES ATTENDED To *(month, year)*	NAME OF PLACE(S) AND ADDRESS

EXAMINATION INFORMATION

Are you a Registered Dietitian (RD) with the Commission on Dietetic Registration (CDR)? ☐ Yes ☐ No ☐ Made application

If No, complete the intern / experience form.

Have you passed an examination offered by the Commission on Dietetic Registration (CDR) for licensure, certification or registration in another state? ☐ Yes ☐ No

EMPLOYMENT INFORMATION

List all professional work experience, full or part time, during the five year period immediately preceding the filing of this application.

NAME AND LOCATION OF FACILITY	JOB TITLE	AREA OF PRACTICE	DATES	
			From *(month, year)*	To *(month, year)*

APPLICATION AFFIRMATION

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

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had membership or privileges revoked, suspended or subjected to any restriction, probation or other type of discipline or limitations? ☐ Yes ☐ 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? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association or institution to release to the Indiana 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 dietitian certification.

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 such information.

I further authorize the Indiana Professional Licensing Agency to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency and the Board 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 hereby swear or affirm under penalties of perjury that the statements made in this application are true, completed and accurate to the best of my knowledge.

Signature of applicant	Date signed *(month, day, year)*