Reset Form

APPLICATION FOR INDIANA DIETITIAN LICENSURE

State Form 47586 (R10 / 3-25)

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 ** ☐ Male ☐ 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.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ 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)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

EDUCATION

List all colleges and universities attended. Official transcript(s) must be provided directly from each institution.

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

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	

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	☐ Full-time ☐ Part-time	Number of hours employed	☐ Full-time ☐ 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	☐ Full-time ☐ Part-time	Number of hours employed	☐ Full-time ☐ 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? ☐ 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. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, 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 such 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, 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*)