Application for Dietitian/Nutritionist Licensure by Examination

Dietetics and Nutrition Practice Council
P. O. Box 6330
Tallahassee, FL 32314-6330

Website: www.floridashealth.gov/licensing-and-regulation/dietetic-nutrition

Email: mqa.dieteticsnutrition@flhealth.gov

Phone: (850) 245-4373

Fax: (850) 414-6860

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor.

Methods of Application

Use the information below to determine the application method you best qualify for.

Examination: This method is for an applicant who has **not** passed the dietetics and nutrition exam developed by the Commission on Dietetics Registration (CDR). Applicants educated outside the United States should select this method.

Examination with Waiver: This method is for an applicant who is a certified nutrition specialist certified by the Certification Board for Nutrition Specialist (CNS) or a Diplomate of the American Clinical Board of Nutrition (DACBN).

Optional Temporary Permit

A temporary permit allows an applicant to work under the supervision of a licensed dietitian/nutritionist for up to one year while the council completes its review of the application and/or successful completion of the examination. Temporary permits are available to any applicant who has completed an application and the Executive Director has preliminarily determined that they appear to be eligible for licensure based on the documentation presented. Refer to Rule 64B8-42.003, Florida Administrative Code (F.A.C.), for more information.

Temporary permits are issued only one time for a limited time.

The **"Dietetics and Nutrition Temporary Permit" form** and required fees must be submitted as part of the completed application. The form may be found at the back of the application and must contain all requested information, which includes original signatures.

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P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 414-6860
Email: mqa.dieteticsnutrition@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

Select one method of application:

Exam - $165.00

Exam with Waiver- $165.00
(Applicant certified by the Certification Board of Nutrition Specialists (CNS) or a Diplomate of the American Clinical Board of Nutrition (DACBN))

CNS #: _____ DACBN#: _____

+ Temporary License (Requires Additional Fee) $50.00 *(Total $215.00)*

Total fee includes the following:

Exam Application Fee (non-refundable)	$80.00
Licensure Fee (refundable)	$80.00
Unlicensed Activity Fee (refundable)	$5.00
+ Temporary Permit (non-refundable)	$50.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to an $85.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male Female

Race: Native Hawaiian or Pacific Islander; American Indian or Alaska Native; Two or More Races; Hispanic or Latino; Black or African American; White; Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the council office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a temporary permit, license/certification, or other authorization, regardless of status, to practice dietetics or nutrition or any health-related profession in any state (including Florida), U.S. territory, or foreign country? Yes No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Verifications are required for each license ever held. Council staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted**.

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

5. EDUCATION HISTORY

A. List college/university education, in chronological order.

School Name and Location	Major	Graduation Date (MM/DD/YYYY)	Degree Awarded

B. What name(s) did you use when you received your education?

_____

All applicants must possess at least a bachelor's degree with a major course of study in human nutrition, food and nutrition, dietetics, food management, or an equivalent major course of study as outlined in s. 468.509, Florida Statutes, and Rule 64B8-42.002, F.A.C.

Transcripts are required for all applicants. Transcripts **must** be submitted directly from the educational institute. However, the applicant may submit their transcripts provided they bear the official seal of the educational institution and be in the institution's sealed envelope. Official transcripts must be sent to the council office at:

Dietetics and Nutrition Practice Council
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

Applicants educated outside of the United States must have a credentials evaluation completed by a credentials evaluation service approved by an accrediting agency approved by the United States Department of Education. See the following page for a list of approved credentialing service providers. The evaluation service must mail the results directly to the council's office at the address listed above.

Important Examination Information

The examination used for licensure in Florida is the Registration Examination for Dietitians administered by the Commission on Dietetic Registration. Once the Dietetics and Nutrition Practice Council has approved your application for examination, the CDR will be notified by office staff.

The CDR will contact the applicant with available exam dates and study materials. Applicants are responsible for scheduling and paying the exam fees to the CDR Computer Based Testing vendor. To ensure the council office receives your scores timely, you must request that your scores be sent to the Florida Dietetic and Nutrition Practice Council. The council office should receive exam scores within three weeks of the exam date. Once the passing scores are received from the CDR, a license number will be issued within two weeks. Allow sufficient time for the office to receive and process exam scores. For detailed information on test administration, study tips, and practice exams, visit www.cdrnet.org.

Applicants requiring special testing accommodations must apply directly to the CDR in accordance with its policies and procedures. You may contact the CDR at www.cdrnet.com or by phone at 1 (800) 877-1600 or direct line at (312) 899-0040 ext. 550.

A certified nutrition specialist who is certified by the Certification Board for Nutrition Specialists or who is a Diplomate of the American Clinical Board of Nutrition is **not required** to pass the Registration Examination for Dietitians administered by the Commission on Dietetic Registration. These applicants must apply under the **"Exam with Waiver"** application method.

Approved Credentialing Service Providers

The credentialing service must provide a detailed course-by-course evaluation to consider your application.

Academic Credentials Evaluation Institute, Inc. (ACEI)
Post Office Box 6908
Beverly Hills, CA 90212, USA
Phone: (310) 275-3528 or (800) 234-1597
Fax: (310) 275-3528
Email: acei@acei1.com
Web: www.acei1.com

Academic and Professional International Evaluation, Inc. (APIE)
Post Office Box 5787
Los Alamitos, CA 90721-5787, USA
Phone: (562) 594-6498
Email: apie@msn.com
Web: www.apie.org

American Education Research Corporation, Inc. (AERC)
Post Office Box 996
West Covina, CA 91793-0996, USA
Phone: (626) 339-4404
Fax: (626) 339-9081
Email: aerc@verizon.net
Web: www.aerc-eval.com

Association of International Credential Evaluators, Inc. (AICE)
Post Office Box 6756
Beverly Hills, CA 90212, USA
Phone: (310) 550-3305 or (888) 263-2423
Email: info@aice-eval.org
Web: www.aice-eval.org

Center for Educational Documentation, Inc. (CED)
Post Office Box 2331126
Boston, MA 02123-1126, USA
Phone: (617) 338-7171
Fax: (617) 338-7101
Web: www.cedevaluations.com

Foreign Educational Document Service
Post Office Box 4091
Stockton, CA 95204, USA
Phone: (209) 948-6589
Web: www.documentservice.org

Foundation for International Services. Inc. (FIS)
14926 35th Avenue West Suite 219
Lynwood, WA 98087, USA
Phone: (425) 248-2255
Fax: (425) 248-2262
Email: info@fis-web.com
Web: www.fis-web.com

International Consultants of Delaware, Inc. (ICDEL)
3600 Market Street Suite 450
Philadelphia, PA 19104, USA
Phone: (215) 222-8454 ext. 510
Fax: (215) 349-0026
Email: icd@icdel.com
Web: www.icdeval.com

International Education Research Foundation (IERF)
Credentials Evaluation Services, Inc.
Post Office Box 3665
Culver City, CA 90231, USA
Phone: (310) 258-9451
Email: www.ierf.org

Josef Silny & Associates
International Education Consultants
7101 SW 102nd Avenue
Miami, FL 33173, USA
Phone: (305) 273-1616
Fax: (305) 273-1338 or (305) 273-1984
Email: info@jsilny.com
Web: www.jsilny.com

SpanTran Educational Services
711 Regency Square Boulevard Suite 205
Houston, TX 77036-3197, USA
Phone: (713) 266-8805
Fax: (713) 789-6022
Web: www.en.spantran-edu.com

World Education Services, Inc. (WES)
Post Office Box 5087
New York, NY 10274-8057, USA
Phone: (212) 966-6311
Fax: (212) 966-6100
Email: info@wes.org
Web: www.wes.org

WES – Branch Offices
Chicago – (312) 222-0336
Miami – (305) 358-6688
Washington, DC – (202) 331-2925

Name: ____

6. EXPERIENCE

Have you completed an internship approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND)? Yes No

If "Yes," skip this section and proceed to section "**8. Health History"** on page 11.

If "No," complete the following sections.

A. Document the required 900 hours of pre-professional supervised experience or equivalent education or experience. (Attach additional sheets if necessary)

Practice Facility		
Name:		
Street:		
City:	State:	ZIP:
Type of Facility:		
Supervisor Name:		
Supervisor License #:		
Start Date (MM/DD/YYYY):	End Date (MM/DD/YYYY):	
# of Hours Per Week:	Total # Hours:	

Practice Facility		
Name:		
Street:		
City:	State:	ZIP:
Type of Facility:		
Supervisor Name:		
Supervisor License #:		
Start Date (MM/DD/YYYY):	End Date (MM/DD/YYYY):	
# of Hours Per Week:	Total # Hours:	

Practice Facility		
Name:		
Street:		
City:	State:	ZIP:
Type of Facility:		
Supervisor Name:		
Supervisor License #:		
Start Date (MM/DD/YYYY):	End Date (MM/DD/YYYY):	
# of Hours Per Week:	Total # Hours:	

Name: _____

Applicants documenting the 900 hours of pre-professional experience in this section must also complete the **"900-hour Pre-Professional Supervised Experience Verification"** form found at the end of the application.

Applicants using additional education or equivalent experience in lieu of 900 hours of supervised experience must document equivalent education or experience in questions B through D below.

B. Document equivalent major course of study to human nutrition, food and nutrition, dietetics or food management.

School Name and Location	Major	Graduation Date (MM/DD/YYYY)	Degree Awarded

C. What name(s) did you use when you received your education?

_____

D. As stated in Rule 64B8-42.002, F.A.C., you may provide documentation of experience equivalent to the 900 hours of pre-professional supervised experience. **List your equivalent experience and attach any supporting documentation to this application.** A curriculum vitae or resume may be included as supporting documentation but is not required. (Attach additional sheets if necessary.)

_____

_____

_____

_____

This information is exempt from public records disclosure.

7. HEALTH HISTORY

The council and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, Florida Statutes, and the applicable statutory practice acts.

The council and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The council and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? Yes No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the council office:

A letter from a licensed health care practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

8. DISCIPLINE HISTORY

A. Have you ever had a health care license to practice any profession revoked, suspended, or otherwise acted against in, including denial of licensure, in a disciplinary proceeding in any state, territory, or country?
Yes No

B. Have you ever been disciplined, terminated, or allowed to resign in lieu of termination from an employment setting where employed as a dietitian/nutritionist, or in any capacity in any other health care profession?
Yes No

C. Have you ever been notified to appear before any licensing authority on a complaint of any nature, including, but not limited to a charge or violation for unprofessional or unethical conduct? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

9. CRIMINAL HISTORY

A. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of dietetics/nutrition? Yes No

B. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

If you responded "Yes" in this section, complete the following: (Attach additional sheets if necessary.)

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

10. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

   If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? Yes No

   If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

All documentation must be submitted or mailed to:

Dietetics and Nutrition Practice Council
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

11. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the council of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

I state that I have read and understand ch. 456 and 468, part X, Florida Statutes, and ch. 64B8, F.A.C., pertaining to the Dietetics/Nutrition Practice Act. I further state that I will comply with all requirements for licensure renewal including continuing education credits.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Dietetics and Nutrition Temporary Permit

This form must be submitted with the application with an additional $50.00 fee.

Applicant Name: _____

Supervised Practice Location

Type of Facility: _____

Name of Facility: _____

Address: _____

City: _____ State: _____ ZIP: _____

Work Phone: _____ Alternate Phone: _____
Input without dashes Input without dashes

Supervisor Information

Supervisor Name: _____

Florida License Number: _____

Title or Position: _____

I will work under the supervision and direction of the aforementioned Florida-licensed dietitian/nutritionist at the listed location.

Applicant Signature: _____ Date Signed: _____
MM/DD/YYYY

I am a Florida licensed dietitian/nutritionist. I agree to provide supervision and direction to the applicant as indicated.

Supervisor Signature: _____ Date Signed: _____
MM/DD/YYYY

Upon review of a request for a temporary permit to practice, a determination will be made pursuant to Rule 64B8-42.003, F.A.C. If a temporary permit is issued, the recipient is required to work under the direct supervision and direction of a Florida licensed dietitian/nutritionist.

Complete verifications must be mailed directly from the licensing agency to:

Dietetics and Nutrition Practice Council
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3257

Dietetics and Nutrition License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Dietetics and Nutrition Practice Council.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

This form must be completed and submitted with the application and fees.

900 Hour Pre-Professional Supervised Experience Verification

The council recognizes that the 900 hours of supervised internship obtained in programs approved by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation and the United States Department of Education satisfies this requirement.

This form is used to document 900 hours of pre-professional supervised experience obtained by means other than those programs. It must be completed for **each** practice location used to meet the 900 hours of supervised practice experience. This form is **not required** from applicants who are documenting experience equivalent to the 900 hours of pre-professional supervised experience.

Attach a copy of the written objectives furnished to the applicant prior to the beginning of the preceptorship.

Applicant Name: _____

To be completed by supervising dietitian/nutritionist

Supervisor Name: _____

Supervisor Address: _____

Supervisor Telephone Number: _____

Were you licensed as a dietitian in Florida at the time you supervised the applicant? Yes No

If "Yes," provide license number: _____

If "No," provide documentation to demonstrate that you were equivalently prepared to be a Florida dietitian/nutritionist. You may provide a copy of the laws and rules by which you were licensed in a different state or country.

Address of supervised experience: _____

Type of Facility: _____ Applicant Title: _____

Dates of supervised experience: _____ to _____
MM/DD/YYYY MM/DD/YYYY

Were you available at all times the applicant performed dietetics and nutrition services for patients?
Yes No

Name: _____

900 Hour Pre-Professional Supervised Experience Verification

Page 2 of 3

Did you provide continuous supervision for the applicant's experience at this facility/location? Yes No

If "No," describe how you were kept informed of the services/activities performed by the applicant.

_____

_____

Provide name(s) and license numbers of supervisor(s) who provided direct supervision and professional responsibility for the applicant's practice at this location.

Name	License #

Was there any relationship between you and the applicant other than the supervisory association?
Yes No

If "Yes," describe the relationship: _____

Rule 64B8-42.002, F.A.C., requires a documented and planned supervised practice experience component in dietetic and nutrition practice of not less than 900 hours, which provided the applicant with a broad spectrum of experiences, including the following:

Completion of a minimum of 200 hours of supervised practice in clinical nutrition (generally acquired in a hospital or other acute or chronic care setting).

Examples of clinical nutrition practice experience are as follows:
1. Assessment of nutritional status for both complex and uncomplicated medical conditions
2. Design and implementation of nutrition care plans
3. Application of medical nutrition therapy for treatment of disease and trauma
4. Selection, implementation and evaluation of nutritional support, such as medical food, enteral and parenteral nutrition regimens
5. Counseling and nutrition education of patients on dietary modifications, including techniques that demonstrate integration of theoretical training, psychological and behavioral aspects of interpersonal relationships, documentation of appropriate interventions, and proper decision-making
6. Performance of basic physical assessments
7. Quality assurance
8. Menu planning for target populations to meet nutritional guidelines and special dietary needs
9. Development or modification of recipes or formulas
10. Food safety and sanitation

Specify the areas of practice and number of hours in clinical nutrition the applicant completed under your supervision.

Area of Practice	Hours Completed

Name: _____

900 Hour Pre-Professional Supervised Experience Verification

Page 3 of 3

Completion of a minimum of 200 hours of supervised practice in community nutrition (generally acquired within a community or public health program or HMO).

Examples of community nutrition practice experience are as follows:
1. Screening/assessment of nutritional status of the population or community group, including counseling techniques that demonstrate integration of theoretical training, psychological and behavioral aspects of interpersonal relationships, documentation of appropriate interventions, and proper decision-making
2. Provision of nutritional care for people of diverse cultures and religions across the lifespan
3. Development, evaluation, or implementation of community-based health promotion program(s)
4. Nutrition surveillance and monitoring of the population or community group
5. General health assessment, e.g. blood pressure and vital signs
6. Development and review of educational materials for the target population
7. Development of food and nutrition policy for the population or community group

Specify the areas of practice and number of hours in community nutrition the applicant completed under your supervision.

Area of Practice	Hours Completed

Identify **all other** areas and number of hours of supervised practice obtained toward completion of the required 900 hours of supervised practice under your supervision.

Area of Practice	Hours Completed

What were the **total hours of practice** the applicant completed under your supervision for the time period being verified on this form? _____

Supervisor Statement

Section 837.06, Florida Statutes, states "Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, Florida Statutes."

I declare that the above information is true and correct to the best of my knowledge. I also declare that I have read Rule 64B8-42.002, F.A.C., and provided written objectives and a planned experience component that meets the requirements of this rule prior to the applicant beginning the preceptorship.

_____ Date: _____

Supervisor Signature MM/DD/YYY

_____ _____

Print Name License and/or RD number (*specify which*)