

## **DIETITIAN APPLICATION INSTRUCTIONS**

### **FEES**

- Application Fee (Non-Refundable): Dietitian - \$100; Provisional Dietitian - \$50
  - Mail application fee with application.
  - Payment can be by check, money order (payable to IDAHO STATE BOARD OF MEDICINE), or credit card (Credit Card Transmittal Form included).

### **APP1**

- Complete all sections.
- If Applicant has not applied for certification/licensure in other states, write "Not Applicable" in the appropriate section.

### **APP2**

- Complete all sections.
- Answer all questions 1-9.
  - Provide details, for YES answers, on a separate sheet.
  - YES answers will require additional documentation (DD-214, court documents, etc.).
- Declaration must be signed by Applicant.

**The above items cannot be faxed or emailed.**

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**The items listed below are to be requested by Applicant and can be faxed or emailed.**

FAX: 208-334-3536; Email: [HP-Licensing@dopl.idaho.gov](mailto:HP-Licensing@dopl.idaho.gov)

### **COPY OF A GOVERNMENT ISSUED ID**

- Examples: Driver's license, passport, etc.

### **NATIONAL EXAM VERIFICATION**

- Board staff will attempt to verify this information online – If staff is unsuccessful, you will be notified.

### **VERIFICATION OF CERTIFICATION/LICENSURE**

- Required from all states in which Applicant holds or has held licensure/certification.
- Verification must be sent from the state of licensure **directly** to the Board of Medicine.

### **PROV1 (VERIFICATION OF PROFESSIONAL EDUCATION) – FOR PROVISIONAL LICENSE ONLY**

- Complete Applicant section only.
- Form must be signed by Applicant.
- Send this form to institution where Applicant completed their didactic program.
  - Registrar/Program Director **must** return completed form **directly** to the Board of Medicine.

### **PROV2 (VERIFICATION OF DIETETIC INTERNSHIP/PRE-PROFESSIONAL PROGRAM) – FOR PROVISIONAL LICENSE ONLY**

- Complete Applicant section only.
- Form must be signed by Applicant.
- Send this form to institution where Applicant completed their internship/pre-professional program.
  - Program/Internship Director **must** return completed form **directly** to the Board of Medicine.

### **PROV3 (MONITOR AFFIDAVIT) – FOR PROVISIONAL LICENSE ONLY**

- Applicants that have not yet passed the CDR exam and are applying for a **provisional** license must submit this form.
- Complete Applicant section only.
- Monitor must be a currently licensed Idaho dietitian.

**No practice is permitted prior to issuance of a license.**

**Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that licensure will be granted.**

**Incomplete applications are held for up to 1 year, after that, all documents will be destroyed.**



## IDAHO STATE BOARD OF MEDICINE

11341 W. Chinden Blvd.  
Building 4  
Boise, Idaho 83714  
(208) 327-7000

Fax (208) 334-3536  
E-Mail [BOM-Licensing@dopl.idaho.gov](mailto:BOM-Licensing@dopl.idaho.gov)  
Website [bom.idaho.gov](http://bom.idaho.gov)

### CREDIT CARD TRANSMITTAL FORM

*For security of your financial information, please **do not email** this form to the Board.*

**Please type or print legibly**

Order Information: \_\_\_\_\_  
(Description of what and who payment is for)

Name as it appears on card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Type of Card          MasterCard          Visa

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_  
(MM)          (YY)

I authorize the Idaho Board of Medicine to charge the above credit card for a one-time payment in the amount of \$ \_\_\_\_\_ .

Printed Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

**Please Note:** The Board of Medicine does not retain your credit card information.

*If you would like to receive a receipt of this transaction, provide your email address below.*

Email Address: \_\_\_\_\_

**IDAHO STATE BOARD OF MEDICINE**

PO Box 83720, Boise, ID 83720-0063  
 Express Mail: 11341 W Chinden Blvd., Bldg. 4, Boise, ID 83714  
 Ph: (208) 327-7000

**APPLICATION – DIETITIAN LICENSE**

| FOR USE OF THE BOARD |        |       |       |
|----------------------|--------|-------|-------|
| FEE                  | GOV ID | CDR   | VER   |
| NPDB                 | PROV1  | PROV2 | PROV3 |

|   |  |                        |
|---|--|------------------------|
| <input type="checkbox"/> <b>Dietitian Application - \$100 (Initial and Endorsement)</b>   | <input type="checkbox"/> <b>Provisional Dietitian Application - \$50</b> |                        |
| <b>Please note:</b> Should your license be issued to you on or before <b>March 30</b> , you will be required to renew by June 30 of that year. If you do not receive a license until after that date, you will not be required to renew until June of the following year. |  |                        |
| <b>Personal Information</b>   |  |                        |
| Full Name (First, Middle, Last, Suffix)   |  |                        |
| Maiden Name or Other Names Used   |  |                        |
| Social Security Number  | Date of Birth (MM/DD/YYYY)   |                        |
| Current Mailing Address   |  |                        |
| City  | State  | Zip Code               |
| Public Address  |  |                        |
| City  | State  | Zip Code               |
| Email Address   |  |                        |
| Telephone Number  | Sex: (Circle One)    Male    Female                                      |                        |
| <b>Name and Location (City/State) of Schools</b>  | <b>From (Month/Year)</b>   | <b>To (Month/Year)</b> |
| Didactic Program in Dietetics   |  |                        |
| Postgraduate Study/Dietetic Internship  |  |                        |

**CDR Registration Number:** \_\_\_\_\_

| List All Licensure/Certification in States and/or Countries – Use Separate Paper if Necessary |                         |             |        |
|---|-------------------------|-------------|--------|
| State   | License/Certification # | Date Issued | Status |
|   |                         |             |        |
|   |                         |             |        |
|   |                         |             |        |
|   |                         |             |        |
|   |                         |             |        |

**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.**

| YES | NO |   |
|-----|----|---|
|     |    | 1. Are you in active service in the U.S. Military, an honorably discharged U.S. Military veteran, or a spouse of either one? If yes, please be prepared to provide additional documentation.  |
|     |    | 2. Have you ever had an application for a professional license/registration denied or refused?  |
|     |    | 3. Have you ever been investigated by any licensing board, hospital, healthcare organization, agency or professional association in connection with incompetency, practice act violations, unprofessional conduct or unethical conduct (even if no action resulted from the investigation)?                                       |
|     |    | 4. Have you ever been found in violation of performing procedures or practicing beyond the scope approved by a licensing or regulatory agency?  |
|     |    | 5. Are you now or have you ever been a defendant in any malpractice proceedings, regardless of the outcome?   |
|     |    | 6. Have you ever been arrested, cited, charged with, or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgments and matters that have been expunged.  |
|     |    | 7. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice your medical profession with reasonable skill and safety? If you are receiving appropriate treatment that allows you to practice safely and without impairment, you may answer NO. |
|     |    | 8. I understand that I am not permitted to practice dietetics as defined in Idaho Code 54-3502A unless I have been issued a license by the State of Idaho?  |

### DECLARATION

I \_\_\_\_\_, certify that I am over 18 years of age and have personal knowledge of the facts set forth herein. I am the person described and identified in this application. I certify that I am the lawful recipient of the educational requirements of Idaho Code Section 54-3506 procured in the regular course of instruction without fraud or misrepresentation.

I further certify that I have read the rules pertaining to Dietetics under Idaho Code Section 54-3501 et. seq. and IDAPA 24.33.07. If a dietetic license is issued to me, I understand that any violation of laws or rules may result in disciplinary action. Should I furnish any false information or cause any material omission in this application, such act constitutes good cause for denial, suspension or revocation of my license.

I understand that the Dietetic Licensure Board and the Division of Occupational and Professional Licenses retains the right to promulgate rules or legislation which may impact the validity of my license.

I certify (or declare) under the penalty of perjury pursuant to the law of the State of Idaho that the foregoing is true and correct.

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

**VERIFICATION OF PROFESSIONAL EDUCATION  
(Provisional License Only)**

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**TO BE COMPLETED BY THE APPLICANT:**

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Full Name of Applicant:

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Address:

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Social Security Number:

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Date of Birth:

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**Applicant's Signature**

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**TO BE COMPLETED BY REGISTRAR OR PROGRAM DIRECTOR:** Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11351 W. Chinden Blvd., Bldg. #4, Boise, ID 83714; Fax: (208) 334-3536.

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Major:

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Degree Received:

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Date of Degree:

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

(SEAL)

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**Please type or print name of Registrar/Director**

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**Signature of Registrar/Director**

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**Name of School or Facility**

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**If changed, present name**

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**City**

**State**

**Zip**

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**Date of this Verification**

**VERIFICATION OF DIETETIC INTERNSHIP/PRE-PROFESSIONAL PROGRAM  
(Provisional License Only)**

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**TO BE COMPLETED BY THE APPLICANT:**

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Full Name of Applicant:

---

Address:

---

Social Security Number:

---

Date of Birth:

---

**Applicant's Signature**

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**TO BE COMPLETED BY APPROPRIATE PROGRAM/INTERNSHIP DIRECTOR:** Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11351 W. Chinden Blvd., Bldg. #4, Boise, ID 83714; Fax: (208) 334-3536.

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Dates of Attendance:

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From (Date):

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To (Date):

As an official of the school named, I certify that the person named above attended program as indicated.

**Director**

(SEAL)

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**Please type or print name of Program/Internship**

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**Signature of Program/Internship Director**

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**Name of Program**

---

**If changed, present name**

---

**City**

**State**

**Zip**

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**Date of this Verification**

**MONITOR AFFIDAVIT  
(Provisional License Only)**

**TO BE COMPLETED BY THE APPLICANT:**

*(This form is required for **provisional** dietitian licensure only.)*

Full Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

*I understand that my provisional license will expire on the 30th day of June following issuance.*

\_\_\_\_\_  
**Applicant's Signature**

**TO BE COMPLETED BY MONITOR:** Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11351 W. Chinden Blvd., Bldg. #4, Boise, ID 83714; Fax: (208) 334-3536.

**FACILITY**

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
\_\_\_\_\_

**SUPERVISOR**

Must be a currently licensed Idaho dietitian.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Idaho License No.: \_\_\_\_\_

**AFFIDAVIT OF MONITOR**

Applicant will work under my personal supervision, and I assume responsibility for the applicant's work as a graduate dietitian during the year of her/his provisional Idaho licensure.

(SEAL)

\_\_\_\_\_  
**Signature of Monitor**

State \_\_\_\_\_ County of \_\_\_\_\_

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

Notary Signature \_\_\_\_\_

My commission expires \_\_\_\_\_