DIETITIAN DOCUMENT INSTRUCTIONS

The items listed below are to be requested by Applicant and <u>can</u> be faxed or emailed.
FAX: 208-334-3536; Email: HP-Licensing@dopl.idaho.gov

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 **<u>directly</u>** 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 **<u>must</u>** return completed form **<u>directly</u>** 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 **<u>must</u>** return completed form **<u>directly</u>** 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.

VERIFICATION OF PROFESSIONAL EDUCATION
(Provisional License Only)

TO BE COMPLETED BY THE APPLICANT:

Full Name of Applicant:	
Address:	
Social Security Number:	**Date of Birth:**

_____

Applicant's Signature

TO BE COMPLETED BY REGISTRAR OR PROGRAM DIRECTOR: Please complete and return form directly to: Idaho Division of Occupational and Professional Licenses, Attn: Allied Health Advisory Board, 550 W. State St. Boise, ID 83702; Fax: (208) 334-3536.

Major:	
Degree Received:	**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)

_____

Please type or print name of Registrar/Director

_____

Signature of Registrar/Director

_____

Name of School or Facility

_____

If changed, present name

_____

City **State** **Zip**

_____

Date of this Verification

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

TO BE COMPLETED BY THE APPLICANT:

Full Name of Applicant:

Address:

Social Security Number:	**Date of Birth:**

_____

Applicant's Signature

TO BE COMPLETED BY APPROPRIATE PROGRAM/INTERNSHIP DIRECTOR: Please complete and return form directly to: Idaho Division of Occupational and Professional Licenses, Attn: Allied Health Advisory Board, 550 W. State St. Boise, ID 83702; Fax: (208) 334-3536.

Dates of Attendance:

From (Date):	**To (Date):**

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

Director

(SEAL)

_____
Please type or print name of Program/Internship

_____
Signature of Program/Internship Director

_____
Name of Program

_____
If changed, present name

_____
City **State** **Zip**

_____
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 Division of Occupational and Professional Licenses, Attn: Allied Health Advisory Board, 550 W. State St. Boise, ID 83702; 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 _____