

DIETITIAN DOCUMENT INSTRUCTIONS

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

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.

**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, 11341 W Chinden
Blvd. Building 4, Boise, ID 83714; 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, 11341 W Chinden Blvd. Building 4, Boise, ID 83714; 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

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

(SEAL)

**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, 11341 W Chinden Blvd. Building 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 _____