



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243**

**TENNESSEE BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
(615) 532-5096 or 1- 800-778-4123 ext. 7413807
www.tn.gov/health**

LICENSURE APPLICATION INSTRUCTIONS AND CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

DONE

- | | |
|--|-------|
| 1. If you have applied to take the American Dietetic Association Examination you may apply for a temporary permit with an additional \$5.00 fee. You must submit proof you are approved to take the exam from A.D.A. and complete steps 2 through 11. | _____ |
| 2. Complete, sign, have notarized and mail the application pages 1 through 6. | _____ |
| 3. Submit a <u>signed</u> passport style photograph taken within the preceding 12 months. (applicant must sign front of photo.) Computer generated images are not acceptable. | _____ |
| 4. Official Transcript - Must be sent to the board directly from the institution. | _____ |
| 5. Submit a notarized copy of current registration with the Commission on Dietetic Registration. A legible <u>notarized</u> photo copy of a <u>current</u> registration card <u>with your signature</u> is acceptable. | _____ |
| 6. Submit one (1) original letter of recommendation from a professional attesting to your personal character and professional ethics. Letter must be on the signature's letterhead written within the past twelve (12) months, and have an original signature. Must be addressed to Board "No Copies" | _____ |
| 7. Submit with your application a check or money order in the amount of \$140.00 made payable to the State of Tennessee. | _____ |
| 8. If you are applying through reciprocity complete steps 2 through 11. Complete and mail Attachment 1 to each state, country, or province in which you hold, or have ever held a license to practice. | _____ |
| 9. If you are currently taking a chemical substance, request from your medical provider a letter to be sent to the Board indicating the medications will or will not affect your abilities to perform as a Dietitian/Nutritionist. | _____ |
| 10. All Applicants for the Dietitian/Nutritionist Examiners must complete and return the Mandatory Practitioner Profile Questionnaire for instructions (click here). | _____ |
| 11. Mandatory Criminal Background Checks are required before you can become licensed for Instructions (click here) | _____ |
| 12. All applicants <u>must</u> complete the Declaration of Citizenship attachment. | _____ |

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Department of Health
Office of Health Related Boards
Board of Dietitian/Nutritionist Examiners
665 Mainstream Drive
Nashville, TN 37243**

or

**For Federal Express or Special Courier:
Tennessee Department of Health
Board of Dietitian/Nutritionist Examiners
665 Mainstream Drive
Nashville, TN 37228**

2. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
3. We will discuss application status with the applicant, applicant's spouse or to whomever hold power of attorney only. Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status must be obtained from you.
4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.
5. Absent any complicating factors, the average application processing time is three weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

Thank you for your cooperation. We will make every effort to process your application in an expeditious and efficient manner.

PLACE
FULL FACE,
PASSPORT SIZE
PHOTOGRAPH
HERE



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

Temporary Permit Fee
3955-006 \$ 5.00

Licensure Fees
3955-001 \$ 75.00
3955-001 55.00
3955-006 10.00
\$140.00

Local (Nashville Calling Area) 615-532-3202
Nationwide (toll free) 1- 800-778-4123 ext. (615) 741-3807
www.tn.gov/health

APPLICATION FOR LICENSURE

APPLICANT: Read all instructions carefully and complete all portions applicable to you.

Please type or print legibly in ink. If a question does not apply to you place a **N/A** in the appropriate space.

PERSONAL INFORMATION

Name: _____
Last First Middle/Maiden

Social Security Number: _____ - _____ - _____ Date of Birth: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §.36-5-1301 (a), as authorized by 42 U.S.C. §405 (c) (2) (C) (i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

U.S. Citizen: YES NO *All applicants **must** complete the Declaration of Citizenship attachment.*

Do you wish to receive notification, including renewal notification, from the Department of Health via email?

YES NO Email Address: _____

Place of Birth: _____ County (TN Applicants Only): _____

Mailing Address: _____ Practice Address: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

(Optional - for statistical purposes only)

Sex: Male Female

Race: _____

LICENSE HISTORY

List below all states in which you have ever been or are currently licensed (in any health profession). If you have not previously been licensed, mark this section N/A. **NOTE: You must request that each state listed send licensure verification directly to the Tennessee Board. (Reference: Licensure Verification Form Attachment 1).**

STATE	LICENSE NUMBER	DATE ISSUED
_____	_____	_____
_____	_____	_____
_____	_____	_____

REGISTRATION

Are you registered by the Commission on Dietetic Registration? Yes [] No []

Registry Number: _____

Date Registered: _____

Are you a current member of the American Dietetic Association? Yes [] No []

Initial Membership Date:

Select Current Status:

Active [] Retired [] Inactive [] Student []

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all post-secondary educational institutions you have attended. Use the back of this page if you need additional space.

From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution (Dietician/Nutrition)	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded

Please complete your entire employment history (relating to dietetics) starting with the most current position first. Use the back of this page if you need additional space.

<u>DATES</u>	<u>LOCATION</u>	<u>POSITION AND DUTIES</u>
From: _____		
Mo/Yr	(City/State)	
From: _____		
Mo/Yr	(City/State)	
From: _____		
Mo/Yr	(City/State)	
From: _____		
Mo/Yr	(City/State)	
From: _____		
Mo/Yr	(City/State)	
From: _____		
Mo/Yr	(City/State)	
From: _____		
Mo/Yr	(City/State)	

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

YES NO

- | | | | |
|----|--|-----|-----|
| 1. | Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? | ___ | ___ |
| | a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? | ___ | ___ |
| | b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? | ___ | ___ |

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances?	_____	_____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety? Submit written explanation of chemical substances.	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever held or applied for a dietitian/nutritionist license or certificate in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
7. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
8. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
9. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
10. Have you ever been rejected or censured by a professional society?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include an interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications.

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

In order to comply with federal statutes, the Board of Dietitian/Nutritionist Examiners is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me, this ____ day of _____, _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

Local (Nashville Calling Area) 615-532-5096
Nationwide (toll free) 1-800-778-4123 ext. 25096

BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
LICENSURE VERIFICATION

Complete Part 1 of this form and mail to each state in which you hold or have held a license. (You are authorized to photocopy the form). Please note that some states may charge a fee for reporting this information.

PART I - MUST BE COMPLETED BY THE APPLICANT

I am applying for a Dietitian/Nutritionist license in Tennessee. I was granted licensure/certification in the State of _____ . My license number is _____ . The Tennessee Board of Dietitian/Nutritionist Examiners requires that I submit verification that my licensure/certification is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board.

Name (Please Print) _____

Signature _____

**PART II - MUST BE COMPLETED BY STATE BOARD
AND SUBMITTED WITH COPY OF LAW, RULES, AND REGULATIONS**

NAME: _____

CERTIFICATION/LICENSE NO. _____

DATE ISSUED: _____ EXPIRATION DATE: _____

LICENSED BY: Reciprocity/Endorsement
 Exam, Specify _____
 Other, Specify _____

Do you show any derogatory information? Yes No

If yes, please explain fully on separate sheet.

BOARD SEAL

SIGNATURE: _____

TITLE: _____

DATE _____

State Board, please return this form to:

**Board of Dietitian/Nutritionist Examiners
665 Mainstream Dr.
Nashville, TN 37243**



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

BOARD OF DIETITIAN/NUTRITIONIST EXAMINERS
(615)-532-5096
1-800-778-4123 ext. 25096

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your educational program.

NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license or limited permit to practice as an Dietitian/Nutritionist in the State of Tennessee. The Board of Dietitian/Nutritionist requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(First) (Middle/Maiden) (Last)

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identified Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

**Board of Dietitian/Nutritionist Examiners
665 Mainstream Dr.
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date



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665 MAINSTREAM DR.
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DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____ - _____ Office: (____)____ - _____ Fax: (____)____ - _____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.