



## **Dietitian/Nutritionist Certification Application Packet**

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### **Important Social Security Number Information:**

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
PO Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Dietitian and Nutritionist Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360.236.4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

**Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

**1: Demographic Information:**

**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

**Legal Name:** List your full name: first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day, and year of your birth.

**Birth Place:** Provide the city, state and country where you were born.

**Address:** List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2: Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3: Education:**

List in date order, most recent to later, the name and location of each college, university, technical or professional school and practice in dietetics or nutrition. Attach additional completed pages if you need more space.

**4: Experience:**

List in date order, most recent to later, your professional work experience. Attach additional completed pages if you need more space.

**5: Other License, Certification, or Registration:**

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if active. Attach additional completed pages if you need more space. Verification of credentials is required on the form provided.

**Note: Many states charge a verification/certification processing fee. Please contact them first to prevent a delay in the review of your application.**

**6: AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in [WAC 246-12-270](#).

**7: Applicant’s Attestation:**

You must sign and date this for us to process the application.

## **Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington**

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at <http://www.doh.wa.gov/hsqa/professions/military/> and include supporting documentation with your application.

## **Certification Requirements**

### **Requirements for Certified Dietitian**

To expedite the credentialing process, include the following information with your application:

- A copy of your current registration card from the Commission on Dietetic Registration (CDR). If you are not registered with the CDR you may request a letter from the CDR attesting you passed the test leading to registration on June 9, 1988.

The following require primary source verification. They will only be accepted when sent to the department from the source. These items should **not** be included with your application. They should be sent directly to the Department of Health, Dietitian/Nutritionist Program, PO Box 47877, Olympia, WA 98504-7877.

1. Evidence of completion of a continuous preprofessional experience or coordinated undergraduate program in dietetics under the supervision of a qualified supervisor.
2. Evidence of having passed the required written exam;
3. Official transcripts showing completion of a baccalaureate degree or higher in a major course of study in one of the following subject areas:
  - Human nutrition.
  - Foods and nutrition.
  - Dietetics.
  - Food management.

### **Requirements for Certified Nutritionist**

Meet the qualifications outlined above for certified dietitian **or**;

Official transcripts showing completion of a masters or doctorate degree in one of the following subject areas:

- Human nutrition.
- Nutrition education.
- Foods and nutrition.
- Public health nutrition.

The college or university is to be accredited by the Western Association of Schools and Colleges or by a national or regional body recognized by the Higher Education Coordinating Board at the time the applicant completed the required education.

You will be notified in writing if more documentation is needed. Please do not call to check on the status of an application.

- The application is considered incomplete if requested information is left blank. State N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020 \(3\)](#).
- You will receive a courtesy renewal notice if your license and address are kept up to date. Any renewal postmarked or sent to the department after midnight on the expiration date is late.

**Note: You cannot practice as a certified dietitian or certified nutritionist until your license is issued.**



## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .....

**Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.**

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .....
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
- b. Diverted controlled substances or legend drugs? .....
- c. Violated any drug law? .....
- d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....

### 3. Education

List in date order, most recent to later, all your education, including college or university, technical or professional school and practice in dietetics or nutrition. Include all periods of time from the date of graduation to present whether or not engaged in activities related to dietetics or general nutrition. Attach additional completed pages if you need more space.

Dates received	Begin date	End date	Name and address of institute or place of practice	Degree/certificate and date received Nature of experience

### 4. Experience

List in date order, most recent to later, your experience. Attach additional completed pages if you need more space.

Name and Location of Institution	From (mm/dd/yy)	To (mm/dd/yy)	Type of Experience or Speciality

### 5. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State/ Jurisdiction	License/Certification/Registration Type	License/Certification/Registration			Method of Licensure		
		Year Issued	Number	Expiration Date	Exam	Endorse	Grand Fathered

## 6. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

## 7. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
(Print applicant name clearly)

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ in \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

By: \_\_\_\_\_  
(Signature of applicant)

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## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#"><u>UDA RCW 18.130</u></a>
Administrative Procedure Act .....	<a href="#"><u>APA RCW 34.05</u></a>
Administrative procedures and requirements.....	<a href="#"><u>WAC 246-12</u></a>
RCW Dietitian/Nutritionist.....	<a href="#"><u>RCW 18.138</u></a>
WAC Dietitian/Nutritionist .....	<a href="#"><u>WAC 246-822</u></a>

### **On-Line**

AIDS Training Resources .....	<a href="#"><u>Reference Page</u></a>
Dietitian/Nutritionist Program.....	<a href="#"><u>Web Page</u></a>