Department of Health & Human Services
DHHS
NEBRASKA

ATTACHMENT
Effective 12/1/2008; revised 4/2013

Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 – 301 Centennial mall South
Lincoln, Nebraska 68509-4986
Phone: 402-471-4359 inna.karpyuk@nebraska.gov

# MEDICAL NUTRITION THERAPY APPLICATION FOR A LICENSE

Please Type or Print Clearly – It is your responsibility to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

## APPLICATION FEE:

Determine the month and year in which you are submitting your application according to the following chart.

| YEAR | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Even** | $114 | $114 | $114 | $114 | $114 | $114 | $114 | $114 | $114 | $114 | $114 | $114 |
| **Odd** | $114 | $114 | 28.50 | 28.50 | 28.50 | 28.50 | 28.50 | 28.50 | $114 | $114 | $114 | $114 |

Make fee payable to "Licensure Unit"
***NOTE: All licenses expire September 1st of odd-numbered years (the renewal fee will be $114)***

**SECTION A – PERSONAL INFORMATION** (All applicants must complete this section)
***NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office or may go on-line to make the change.***

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | Legal Name | First: | Middle/MI: | Last: | | |
| | Maiden Name | Name: | Other Names you are known as (AKA): | | | |
| 2 | Mailing Address | Street/PO/Route: | | | | |
| | | City: | State or Country: | Zip: | | |
| 3 | Date of Birth: Month/Day/Year | | Place of Birth: City/State or Country | | | |
| 4 | Check the Appropriate Box(s): | ☐ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); or ☐ Form I-94 (Arrival-Departure Record) number: | SSN# | | | |
| | | | A# | | | |
| | | | I-94 # | | | |
| | If you have both a SSN and an A# or I-94 number, you must report both. Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information. | | | |
| 5 | Phone #: (optional) | | Fax #: (optional) | | E-Mail Address: (optional) | |

| **SECTION B – LICENSURE APPLICATION CATEGORY** (All applicants must check the appropriate application method) | | | | |
|---|---|---|---|---|
| **Initial Licensure:** | | | | |
| ☐ | **Option 1:** Application based on being a Registered Dietitian with the American Dietetic Association (ADA). You must submit official documentation of being a Registered Dietitian with the ADA or an equivalent entity. | | | |
| | Registration Number: | | Date Issued: | |
| | If not ADA name of equivalent entity: | | | |
| ☐ | **Option 2:** Application based on a baccalaureate degree from an accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, or an equivalent major course of study AND Completion of a program of at least 900 supervised clinical experience (Attachment A1 must be completed as verification); | | | |
| ☐ | **Option 3:** Application based on a master's or doctoral degree from an accredited college or university in human nutrition, nutrition education, food and nutrition, or public health nutrition or in an equivalent major course of study. | | | |
| ☐ | **Option 4:** Application based on a master's or doctoral degree from an accredited college or university which includes a major course of study in clinical nutrition with not less than a combined 200 hours of biochemistry and physiology and not less than 75 hours in human nutrition (Section D must be completed as verification). | | | |
| **Reciprocity:** | | | | |
| ☐ | Application based on holding a license/certification in another jurisdiction for at least one full year, and practicing under such license/certification in the other jurisdiction for at least one of the three years immediately preceding applying for licensure in Nebraska. | | | |

**SECTION C – CONVICTION AND LICENSURE INFORMATION** (All applicants must complete this section)
**Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.**

**NOTE:** If you have any criminal charges or license disciplinary actions pending that result in a misdemeanor or felony conviction or license discipline, you must report such actions to the Investigative Unit within 30 days of the conviction/action (Neb. Rev. Stat. 38-1,125) at http://www.dhhs.ne.gov/reg/investi.htm or by requesting a reporting form by telephone at 402-471-0175.
**Answer each of the following questions by placing a (✓) in the appropriate box (yes or no) and completing the information requested. All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see page 5 of application).**

**Conviction Information:**

| # | Question | Yes | No | Type of Crime or Licensure Action | Date of Action | Name of Court/Entity Taking action |
|---|---|---|---|---|---|---|
| 1 | Have you **EVER** been convicted of a misdemeanor or felony? | ☐ | ☐ | | | |
| | | | | | | |
| | | | | | | |

**Licensure Information:**

The following questions relate to a credential that you hold or have held in health services, health-related services or environmental services in another jurisdiction.

| | | Yes | No | | | |
|---|---|---|---|---|---|---|
| 2 | Do you hold or have you held a license in any state? | ☐ | ☐ | If yes, what State(s) are you licensed in? | What type of license do you hold? | |
| | | | | | | |
| | | | | | | |
| 3 | If you answer 'yes' to question 2, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it? | ☐ | ☐ | Type of Licensure Action | Date of Action | Name of Entity taking Action |
| | | | | | | |
| | | | | | | |
| 4 | Have you ever been denied the right to take a credentialing examination? | ☐ | ☐ | Please Explain: | | |

**ONLY COMPLETE THIS SECTION IF YOU APPLIED UNDER OPTION 4**

**SECTION D** - EXPERIENCE (If you are applying for licensure based on a master's or doctoral degree which included a major course of study in clinical nutrition, you must complete the appropriate section below IF YOU ARE APPLYING BY OPTION 4).

MASTER'S OR DOCTORAL DEGREE I have completed a master's or doctoral degree which included a major course of study in clinical nutrition and consisted of not less than a combined 200 hours of biochemistry and physiology and not less than 75 hours in human nutrition. List qualifying courses, number of academic hours earned for each course listed:

| Name of Biochemistry and Physiology Courses | Hours | Name of Human Nutrition Courses | Hours |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***Hours are calculated as:**
**1 semester hour = 15 clock hours; 1 quarter hour = 10 clock hours; 1 trimester hour = 14 clock hours**

**SECTION E - EDUCATION** (All applicants must complete this section, **EXCEPT THOSE APPLYING UNDER OPTION 1). Check the appropriate response.**

| | | | |
|---|---|---|---|
| ☐ | Transcript attached | | |
| ☐ | Transcript forwarded separately | Last name on the transcript: | |

**(If you are applying for licensure based on being a Registered Dietitian with the American Dietetic Association (ADA) you *do not* need to submit an official transcript)**

| | | | |
|---|---|---|---|
| INSTITUTION Name: | | | |
| Address: | Street/PO/Route | | |
| | City | State | Zip |
| Month and Year degree granted: | | Degree: | Major: |

**SECTION F – PRACTICE PRIOR TO CREDENTIAL**

An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

| | | |
|---|---|---|
| 1 | I have practiced medical nutrition therapy in Nebraska before submitting the application? | ☐ Yes ☐ No |
| 2 | If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice: | # of days: _____ |
| | | Name of Business: |
| | | City: |
| | | Telephone #: |

## SECTION G - ATTESTATION

**Lawful Presence in the United States Attestation:**

For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

**Please check ONLY ONE of the boxes below:**

- ☐ I am a citizen of the United States; or
- ☐ I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or
- ☐ I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

**Alien or Non-Immigrant Status:** If you are a qualified alien lawfully admitted into the United States OR a non-immigrant lawfully present in the United States, you must submit evidence of lawful presence which may include a copy of:

1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card; or
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
3. A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Document is **NOT** acceptable; or
4. A Form I-94 (Arrival-Departure Record).

If you are an Alien or Non-Immigrant, your credential will **NOT** be issued until such proof is received by our office and your documents are verified by our office through the Department of Homeland Security. This process may take four to six weeks.

**Application Attestation:** I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good character.

Print Name: _____

Signature: _____ Date: _____


**NOTE: In order for your application to be considered complete, all applicants MUST also submit a copy of the following documents:**

1. ☐ Age: Evidence of at least 19 years of age (i.e.: driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or similar documentation);

2. ☐ Citizenship, lawful permanent residence, and/or immigration status Information: You must submit a **copy** of at least one of the following documents:
   (a) A U.S. Passport (unexpired or expired);
   (b) A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal (Hospital issued birth certificates cannot be accepted);
   (c) An American Indian Card (I-872);
   (d) A Certificate of Naturalization (N-550 or N-570);
   (e) A Certificate of Citizenship (N-560 or N-561);
   (f) Certification of Report of Birth (DS-1350);
   (g) A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
   (h) Certification of Birth Abroad (FS-545 or DS-1350);
   (i) A United States Citizen Identification Card (I-197 or I-179);
   (j) A Northern Mariana Card (I-873);
   (k) A Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
   (l) An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
   (m) A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Documents is NOT acceptable; or
   (n) A Form I-94 (Arrival-Departure Record);

3. ☐ Application Method and Education:
   ☐ Option 1 - CDR Registration: If applying based on CDR registration, you must submit official documentation of being a Registered Dietitian with the ADA or an equivalent entity.
   ☐ Option 2: You must submit Attachment A1 and a copy of your official college/university transcript
   ☐ Option 3 and 4: You must submit a copy of your official college/university transcript

4. ☐ Conviction Information: If you have been convicted of a felony or misdemeanor, you must submit:
   (a) A copy of the court record, which includes charges and disposition;
   (b) Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;
   (c) All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
   (d) A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation;

5. ☐ Other Credentialing Info: If you hold or have held a credential to provide health services, health-related services, or environmental services in another jurisdiction, you must have the licensing agency submit to the Department a certification of your credential;

6. ☐ Disciplinary Action: If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition;

7. ☐ Fee: The required fee (see chart on page 1 of this application).

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health – Licensure Unit
P.O. Box 94986, 301 Centennial Mall South
Lincoln, Nebraska 68509-4986
402-471-4359 inna.karpyuk@nebraska.gov

**REQUIRED IF YOU APPLIED UNDER OPTION 2**

# AFFIDAVIT OF SUPERVISED EXPERIENCE IN MEDICAL NUTRITION THERAPY

(Print or Type)

**Option 2:** Application based on a baccalaureate degree from an accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, or an equivalent major course of study AND Completion of a program of at least 900 supervised clinical experience (Attachment A1 must be completed as verification)

I, _____, state that I am a
(supervisor's name)

qualified supervisor licensed in the profession of Medical Nutrition Therapy, License # _____ and

that I am acquainted with _____, and he/she
(applicant's name)

has completed not less than 900 hours of a planned continuous clinical experience in human nutrition,

food and nutrition, or dietetics under my supervision.

_____
Date

_____
(Print/type) SUPERVISOR Name Title

_____
License number
of Supervisor

_____
Agency/Institution

_____
Street Address

_____
City State Zip

_____
Supervisor's *Signature*

FORWARD THIS COMPLETED FORM TO:

NEBRASKA Department of Health and Human Services
Division of Public Health - Licensure Unit
Medical Nutrition Therapy
P. O. Box 94986, 301 Centennial Mall South
LINCOLN, NE 68509-4986

**YOU MAY MAKE ADDITIONAL COPIES OF THIS FORM IF SUPERVISED BY MORE THAN ONE SUPERVISOR**