

**NORTH DAKOTA BOARD OF DIETETIC PRACTICE**  
**Application for Licensure**  
**General Information**

**Office Use Only:**

**Date Received:** \_\_\_\_\_ **Fee Received:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Maiden

Preferred mailing address: \_\_\_\_\_  
Street City State Zip Code

Home Address: \_\_\_\_\_  
Street City State Zip Code

Home telephone number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Do you have a National Provider Identifier (NPI) from the Centers for Medicare and Medicaid Services?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, List your Number: \_\_\_\_\_

List each professional school attended and year of graduation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you possess professional license(s) or certificate(s) issued by another organization or state?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had your professional license(s) or certificate(s) revoked, canceled, or suspended?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, attach an explanation.

Have you ever been convicted of a felony or misdemeanor? If yes, attach an explanation.  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please attach an explanation.

**CURRENT EMPLOYMENT INFORMATION**

Place of employment: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone number: \_\_\_\_\_ Job title: \_\_\_\_\_

Organization Type:  
(i.e. health care facility; pharmaceutical sales; government agency; public health unit)

\_\_\_\_\_

Are you self employed? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have your own corporation that you professionally practice dietetics under? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list the name of the corporation or business name:

\_\_\_\_\_



**STANDARDS OF PROFESSIONAL RESPONSIBILITY**

I have read and agree to abide by Chapter 43-44 of the North Dakota Century Code (dietitians and nutritionists) and the rules and regulation of the North Dakota Board of Dietetic Practice.

I agree to hold the North Dakota Board of Dietetic Practice, its members, officers, agents, and examiners free from any damage or claim for damage or complaint by reason of any action they or any one of them take in connection with this application, the failure of the Board to issue me a license and any other aspect of licensing. I hereby grant permission to the Board to seek any information or references it deems fit in securing my credentials pertinent to this application.

I further agree that if issued a license, upon the revocation, suspension or cancellation of the license, I shall return the license certificate and license identification card to the Board.

The information which I provide in this application is truthful and I understand that providing false information of any kind may result in the voiding of this application.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of applicant (must be notarized)

Sworn to me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Name

My commission expires: \_\_\_\_\_