



DIETITIANS VERIFICATION OF LICENSURE IN OTHER JURISDICTIONS INSTRUCTIONS

All information provided must be typed or printed in **black ink**.

PART 1 MUST BE COMPLETED BY THE APPLICANT

1. APPLICANT NAME – Write your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. STATE WHICH REQUESTED VERIFICATION IS NEEDED – List the jurisdiction you need verification for your license.
3. LICENSE NUMBER – List the number issued in the other jurisdiction.
4. LICENSE ISSUE DATE – List the date the license was issued in the other jurisdiction.
5. PHONE NUMBER – Write a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
6. EMAIL ADDRESS – Write your email address. Please provide your email address so the department may email license information and required notices to you. Your email address is confidential pursuant to the Texas Public Information Act, and the department will not share it with the public. (Required)
7. APPLICANT SIGNATURE AND DATE - Signature and date of the requesting applicant.

Send the form to the State Board verifying your licensure and you are responsible for paying any fees required for license verification in other states.

PART 2 MUST BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE

8. LICENSEE NAME – Write the legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
9. LICENSURE LEVEL –
10. LICENSE NUMBER – List the license number issued to the requestor.
11. LICENSE ISSUE DATE – Date the license was issued to the requestor.
12. PLEASE VERIFY SUPERVISION REQUIREMENTS WERE MET IN YOUR JURISDICTION – Please give the supervision dates, the number of months credited, the employer's name and address, the supervisor's name and phone number, total hours of practice and the number of hours of direct clinical services.
13. EXAM TAKEN – Indicate if the exam was done by CDR or list other method, the exam date and score on the test.
14. LICENSE CURRENT – Indicate if the license is current and list the license expiration date.
15. COMPLAINTS AND/OR DISCIPLINARY ACTIONS – Indicate by placing a check by Yes or No and include a description of complaint or disciplinary action.
16. NAME OF VERIFYING OFFICIAL – Enter the name, title and contact number of the individual that supplied the information from the licensing agency.

Mail or Fax the form to TDLR, please use the contact information on the top of this form.



**DIETITIANS VERIFICATION OF LICENSURE IN
 OTHER JURISDICTIONS**

DO NOT WRITE ABOVE THIS LINE			
All information provided must be typed or printed in <u>black ink</u>.			
PART 1 MUST BE COMPLETED BY THE APPLICANT			
1. Applicant Name:			
Last	First	Middle Name	Suffix
2. State from which verification requested:	3. License Number:	4. License Issue Date:	
5. Personal Phone Number: ()		6. Email Address:	
Area Code	Number	(Ex: johndoe@aol.com) See Instructions sheet for Disclosure)	
7. Applicant Signature and Date:			
Signature			Date
PART 2 MUST BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE			
8. Licensee Name:			
Last	First	Middle Name	Suffix
9. Licensure level:	10. License Number:	11. License Issue Date:	
12. Verify supervision requirements met in your jurisdiction:			
Supervision dates, From: _____		To: _____	
		Number of months credited: _____	
Employer name: _____		Employer Address: _____	
Supervisor name: _____		Phone Number: _____	
Total hours of practice: _____		Number of hours of direct clinical services: _____	
13. Exam Taken:			
<input type="checkbox"/> (CDR) Other: _____		Date Exam Passed: _____	
		Exam Score: _____	
14. License Current? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____			
15. Complaints and/or Disciplinary Action: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain below)			
16. Name of verifying official:			
Print Name			Date
Signature			Title
			Date