



**ARKANSAS DIETETICS LICENSING BOARD**  
**P.O. BOX 1016**  
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**VERIFICATION OF LICENSURE**

**THIS FORM MUST BE COMPLETED BY THE STATE REGULATORY AGENCY IN EACH STATE FROM WHICH YOU HOLD A LICENSE TO PRACTICE.**

Name of Applicant \_\_\_\_\_ CDR# \_\_\_\_\_ LD# \_\_\_\_\_

Profession in Which License was issued \_\_\_\_\_ Dietetics \_\_\_\_\_

Name of State Issuing License \_\_\_\_\_ AR \_\_\_\_\_

Original Date License Issued \_\_\_\_\_ Current \_\_\_\_\_ Not Current \_\_\_\_\_

If Not Current Explain Why Not \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Dates of Disciplinary Action (If Applicable) \_\_\_\_\_

Reason for Disciplinary Action \_\_\_\_\_

License Issued On The Basis of \_\_\_\_\_ Registered Dietitian \_\_\_\_\_

**I HEREBY CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT BASED ON RECORDS AVAILABLE TO ME THE APPLICANT WAS COMPETENT TO PRACTICE WHILE LICENSED IN THIS STATE.**

\_\_\_\_\_  
**Name of Official of Agency**

\_\_\_\_\_  
**Original Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
 Date