Instructions for Applicant Renewal

- Incomplete applications will be returned to applicant.
- Renewal Applicants complete Form ADLB 2. Renewal applications do not require notarizing.
- Type or Print Legibly. Place your name on each of the forms.
- Allow up to 2 weeks for the Application process to be completed.
- Send all completed, signed application materials, as applicable and NONREFUNDABLE application fees to:

  Arkansas Dietetics Licensing Board  
  P. O. Box 1016  
  North Little Rock, Arkansas 72115

✓ Make check or money order payable to:

  Arkansas Dietetics Practice Fund

✓ **DO NOT SEND CASH. IT WILL BE RETURNED WITH APPLICATION**

<table>
<thead>
<tr>
<th>FEE SCHEDULES</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Renewal Fee (licensure year 12/1-11/30)</td>
<td>$50</td>
</tr>
<tr>
<td>Late Fee Dec. 1-Feb. 28 + $25</td>
<td></td>
</tr>
<tr>
<td>Late Fee March 1-Nov. 30 + $50</td>
<td>Total $100</td>
</tr>
<tr>
<td>Duplicate/Replacement Card</td>
<td>$25</td>
</tr>
</tbody>
</table>
RENEWAL - DECEMBER 1, 2021 – NOVEMBER 30, 2022

APPLICATION FOR Licensed Dietitian

Renewal applicant. *Submit documentation of 12 continuing education units dated November 1, 2020 to October 31, 2021.*

Complete the following application. **Incomplete packets will be returned.**

The following information is being requested in compliance with ARK. Code Ann. 25-1-117.

SOCIAL SECURITY NUMBER __________________ DATE OF BIRTH __________________

PLACE OF BIRTH
City State County Country

GENDER ( ) Male ( ) Female

RACE; ( ) White ( ) Black/African American ( ) Asian ( ) American Indian/Alaska Native ( ) Other ________________________________

ETHNICITY: ( ) Hispanic or Latino ( ) Not Hispanic or Latino

EDUCATIONAL INSTITUTION OF PROFESSIONAL EDUCATION AND TRAINING: ________________________________

RD# ____________________________ LD# ____________________________

Applicant’s Name __________________________________________________________

Last First Middle Maiden

Home address _________________________________________________________________

Street or Box Number City State ZIP

County ________________

Phone: Home ( ) Work ( ) Cell ( )

PLEASE CIRCLE BEST CONTACT NUMBER

Email address ____________________________

PLEASE PRINT CLEARLY

☐ I am submitting a photocopy of current CDR registration card dated 9/01/2021 - 8/31/2022 or greater.
Are you considered an Arkansas State Employee? (example: School Food Service; Cooperative Extension; UAMS; AR Dept of Health or Arkansas City or County) Employee. Yes_______ No__________

Employer: ____________________________________________________________

Address: _______________________________________________________________

City_____________ State_______ Zip Code_______ County________________________

Telephone: ________________________________

Your Job Title: ________________________________

Have you ever had a license, registration, or certification as a Dietitian denied, revoked, cancelled, or suspended? YES_____ NO______. If YES, briefly state the reason
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you ever been convicted of a felony or misdemeanor? YES_____ NO ______
If Yes, provide Date of Conviction________ Where convicted ______________________ Charge______________ If conviction was set aside, give date and explain, using additional pages if necessary ________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

This information must be provided yearly.

ALL renewal applicants must sign.
I have completed this application for licensure to the best of my ability and affix my signature that all facts and information provided are true and accurate.

________________________________________________________________________
(Signature- required) (Date
________________________________________________________________________
________________________________________________________________________

ADLB OFFICE USE ONLY

Date Received____________ CPE Units___________
Amount Received__________ CDR Card __________
Check # __________________ Money Order # ___________
Date Approved_________________