TEXAS DEPARTMENT OF LICENSING & REGULATION
P.O. Box 12157 • Austin, Texas 78711-2157
www.tdlr.texas.gov

DIETITIANS VERIFICATION OF LICENSURE IN OTHER JURISDICTIONS INSTRUCTIONS

PART 1 MUST BE COMPLETED BY THE APPLICANT

1. APPLICANT NAME – Provide 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 – Provide the jurisdiction you need verification for your license.
3. LICENSE NUMBER – Provide the license number issued in the other jurisdiction.
4. LICENSE ISSUE DATE – Provide the date the license was issued in the other jurisdiction.
5. PHONE NUMBER – Provide 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 – Provide 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 – Provide 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 – Provide level of licensure.
10. LICENSE NUMBER – Provide the license number issued to the requestor.
11. LICENSE ISSUE DATE – Provide the 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.

SEND YOUR COMPLETED REQUEST AND REQUIRED DOCUMENTS TO:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your request will not be returned. Keep a copy of your completed request, all attachments, and your check or money order. Do not send cash.

For additional information and questions, visit the ***TDLR website*** or reach Customer Service via ***webform***. The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800) 735-2989.

TDLR PUBLIC INFORMATION ACT POLICY:
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DIETITIANS VERIFICATION OF LICENSURE IN OTHER JURISDICTIONS

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

PART 1 MUST BE COMPLETED BY THE APPLICANT

1. Applicant Name:

Last _____ First _____ Middle _____ Suffix _____

2. State from which verification requested:	**3. License Number:**	**4. License Issue Date:**

5. Personal Phone Number:	**6. Email Address:**
(Area Code) Phone 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 _____ 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:

☐ (CDR) Other: _____ Date Exam Passed: _____ Exam Score: _____

14. License Current? ☐ Yes ☐ No Expiration Date: _____

15. Complaints and/or Disciplinary Action: ☐ Yes ☐ No (If Yes, explain below)

_____

_____

_____

16. Name of verifying official:

Print Name _____ Date _____

Signature _____ Title _____ Date _____