| FOR OFFICE USE | |
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# APPLICATION FOR THE REGISTRATION EXAMINATION FOR DIETETIC TECHNICIANS

Directions for completing this application are provided in detail in the *Handbook for Candidates.* Please follow the directions carefully as you complete this form. You must complete and return this original application form; copies of applications will not be accepted. No other documents are required for submission with this application. After you have completed this application, return it with a check or money order, or complete the credit card charge box. The fee of $80.00 is made payable to: Dietetic Registration (82), ACT, P.O. Box 168, Iowa City, IA 52243-0168.

**A.** If your name and/or address are different from the label shown at the left, print the corrected information only on the appropriate line(s) below.

Last Name First Name MI

ADA Identification Number

New Address

City State ZIP Code

**B.** Check the pathway, which best explains how you met eligibility requirements to take the Registration Examination for Dietetic Technicians. Provide any additional information requested. Refer to the *Handbook for Candidates.* Select only one pathway. Please print.

❑ 1. **Dietetic Technician Program** (See Handbook Code Numbers List.)

| Code | Name of Institution | City | State | Month/Year Completed |
|---|---|---|---|---|

❑ Yes
❑ No
I authorize ACT to release my test results with my name to the Program Director of the above Dietetic Technician Program. Test results are only used by Program Directors as part of ongoing program evaluation to improve program effectiveness.

❑ 2. **Didactic (Baccalaureate) Program in Dietetics Graduate with CADE Accredited Dietetic Technician Program Experience.**

a. **Didactic Program in Dietetics**. (See Handbook Code Numbers List.)

| Code | Name of Institution | City | State | Month/Year Completed |
|---|---|---|---|---|

❑ Yes
❑ No
I authorize ACT to release my test results with my name to the Program Director of the above Didactic Program. Test results are only used by Program Directors as part of ongoing program evaluation to improve program effectiveness.

b. **Dietetic Technician Program** where experience component was completed. (See Handbook Code Numbers List.)

| Code | Name of Institution | City | State | Month/Year Completed |
|---|---|---|---|---|

❑ Yes
❑ No
I authorize ACT to release my test results with my name to the Program Director of the above Dietetic Technician Program. Test results are only used by Program Directors as part of ongoing program evaluation to improve program effectiveness.

❑ 3. **Reregistration.** (Previously held dietetic technician, registered status.)

SAMPLE

Over, please

**C.** Indicate your sex

- ❑ 1. Male
- ❑ 2. Female

**D.** Social Security Number

___ - ___ - _____

**E.** Please check to see that you have filled out this form completely. Sign your name on the line below and provide a telephone number, FAX number or E-mail address where you may be reached during the day.

Signature ____________________

Home Telephone Number (include area code) ____________________

FAX Number ____________________

Work Telephone Number (include area code) ____________________

E-mail Address ____________________

**F.** You have the option of enclosing a check for the fee or charging the fee to VISA® or MasterCard®.
If you choose to charge, please complete the following:

Type of Card:

- ❑ VISA
- ❑ MASTERCARD

Card Number: ____________________

Expiration Date: Month ___ Year ___

Amount $ ______.___

Name on Credit Card ____________________
PLEASE PRINT

Card Holder Signature ____________________

SAMPLE

## ASSURANCE OF CONFIDENTIALITY

**Disclosing information on examination content compromises the security, integrity and reliability of the examination. I agree that I will not disclose any information related to the examination questions to anyone, including examination candidates, educators or review course providers.**

**Signature** ____________________ **Date** ____________________

**Disability Accommodations**

Candidates who have a physical, mental, or sensory disability, as defined by the Americans with Disabilities Act, may request accommodations by following the guidelines in the Handbook.

All supporting documentation regarding disability accommodation(s) **must** be sent to ACT **with** the completed application form and fee.

Include with your documentation a description of the specific accommodation(s) you are requesting (e.g., wheelchair access, extended time). **If additional testing time is requested, you must state the precise amount of additional time needed**; for example, time-and-a-half, one-third more time. The need for additional time must be documented by a physician or other appropriate professional.

Reasonable accommodations will be provided for persons with disabilities who follow these instructions.

**NOTE:** Candidates who have a medical reason for needing food or drink during the test session must provide supporting medical documentation to ACT with the completed application form.

**Please send your application form, fee, and any special requests and supporting documentation to: Dietetic Registration (82), ACT, P.O. Box 168, Iowa City, IA 52243-0168.**