

APPLICATION FOR THE REGISTRATION EXAMINATION FOR DIETITIANS

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 \$125.00 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

Licensure only candidates, please skip Sections B and C and proceed to Section D.

B. Check the pathway, which best explains why you are eligible to take the Registration Examination for Dietitians. Provide any additional information requested. Refer to the *Handbook for Candidates*. Select only one pathway. Please print.

1. **Coordinated Program** (Please skip Section C and continue with Section D.)

Code	Name of Institution	City	State	Month/Year Completed
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Yes I authorize ACT to release my test results with my name to the Program Director of the above Coordinated Program. Test results are only used by Program Directors as part of ongoing program evaluation to improve program effectiveness.

No

2. **Internship Program or Approved Preprofessional Practice Program** (Please also complete Section C.)

Code	Name of Institution	City	State	Month/Year Completed
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Please check one of the following for Internship or Approved Preprofessional Practice Program.

Yes I authorize ACT to release my test results with my name to the Program Director of the above Internship Program. Test results are only used by Program Directors as part of ongoing program evaluation to improve program effectiveness.

No

- | | | |
|---|---|---|
| <input type="checkbox"/> 3. Three-Year Preplanned Experience Program | <input type="checkbox"/> 8. Traineeship | <input type="checkbox"/> 13. United Kingdom Reciprocity |
| <input type="checkbox"/> 4. Qualifying Experience with Advanced Degree: Assistantship | <input type="checkbox"/> 9. Canadian Reciprocity | <input type="checkbox"/> 14. Reregistration (previously held registered dietitian status) |
| <input type="checkbox"/> 5. Qualifying Experience with Advanced Degree: Six Months | <input type="checkbox"/> 10. Philippine Reciprocity | |
| <input type="checkbox"/> 6. Qualifying Experience with Doctoral Degree | <input type="checkbox"/> 11. Dutch Reciprocity | |
| <input type="checkbox"/> 7. Three-Year Non-Preplanned Experience Program | <input type="checkbox"/> 12. Irish Reciprocity | |

Note: ONLY the Internship Candidates should complete this section. Coordinated Program graduates and Pathways 3 - 14 should not complete this section.

C. **Didactic (Baccalaureate) Program in Dietetics:** Indicate the code number, name, city, and state of the institution and year you completed the academic requirements. Please list only one institution.

Code	Name of Institution	City	State	Year Completed
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Yes I authorize ACT to release my test results with my name to the Program Director of the above Didactic Program in Dietetics. Test results are only used by Program Directors as part of ongoing program evaluation to improve program effectiveness.

No

Over, please

<p>D. Indicate your sex</p> <p><input type="checkbox"/> 1. Male</p> <p><input type="checkbox"/> 2. Female</p>	<p>E. Social Security Number</p> <p>_____</p>
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F. 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

G. 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: _____

Amount \$ _____

Name on Credit Card: _____

Card Holder Signature: _____

SAMPLE

PLEASE PRINT

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 supportive 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 supportive medical documentation to ACT with the completed application form.

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