RENEWAL APPLICATION FOR DIETITIAN LICENSURE

Your Dietitian license will expire February 28

Name_______________________________
Address_____________________________
City, State, Zip_______________________
Email_______________________________

License#: ____________
Renewal Fee: $135
CE Hrs Due: 15
Fee waived for Military Spouses see below for details

NOTE: ONLY use this application form if NOT using the online renewal process.

Disciplinary/Conviction History
To renew your license the following question must be answered:

During this licensure period, has your license, certification, or registration issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any disciplinary action, or have you been convicted of a crime by any state or federal court in the Unites States?
( ) No ( ) Yes If yes, attach explanation.

Continuing Education Attestation
The following attestation statement regarding continuing education must be signed to renew your license:

By signing this application, I affirm that I have completed the continuing education required by regulation (KAR 28-59-5). I understand that an audit will be conducted of a percentage of all applications, and should my application be subject to audit, I will provide all documentation as requested . I understand that my license will not be renewed until all required documentation is reviewed and approved. I also know that falsifying any of this documentation may result in disciplinary action against my license.

Signature____**Date**____________________

If *NOT* renewing please indicate below:
I do not intend to renew my Kansas Dietitian license at this time because:
____

Attention: **if you are a military spouse who resides or plans to reside in this state due to the assigned military station of the individual's spouse, please complete this paper renewal form and return with a copy of documentation which reflects military affiliation. No fee will be required at this time, unless after review it has been determine you don't meet the requirements for the fee to be waived.**

(Please return this application to the address below so we can update your records)

Before mailing your renewal application please assure that you have:

•**Enclosed** a nonrefundable fee of $135.00 made payable to the Kansas Dept for Aging and Disability Services (KDADS). Or completed and enclosed the authorization form to charge fees to your Visa or MasterCard.
•**Answered** the disciplinary question.
•**Signed** the continuing education attestation.
NOTE: As mentioned above, applications postmarked after 02/28 and before 04/01 can still be processed for renewal if the required CE was obtained by 02/28 but a $50 late fee must be paid in addition to the $135 renewal fee. After 03/31, licenses are considered lapsed and would have to be reinstated. The fee for reinstatement is $235.

Please submit application materials to:
KDADS.Licensure@ks.gov
or mail to:
Health Occupations Credentialing 503
S Kansas Ave, Suite 300 C Topeka, KS
66603-3404

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
HEALTH OCCUPATIONS CREDENTIALING
CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD

NAME OF INDIVIDUAL: ____
Please Print

As payment of fees for:

Certification CNA/CMA/HHA ONLY
Course # ______________
________ Certified Nurse Aide
________ Interstate
________ Certified Home Health Aide
________ Certified Medication Aide
________ CMA Renewal
________ Reschedule State Test
________ Allied
Fee amount paid

Licensing - SLP, Audiology, Diet, Admin, Operator		
Circle Type to Select	enter credential number if known or X if new	
Temporary	______	Speech Language Pathologist
Initial/Full	______	Audiologist
Reciprocal	______	Dietitian
Renewal	______	Adult Care Home Administrator
Reinstatement	______	Operator Registration
$	Fee amount paid	***Fees are waived for military spouses***

FACILITY USE ONLY
FACILITY NAME AND ID FOR CRC: ____

Criminal Record Check - Facility Use Only	
Number of names checked:	______
$10.00 per name	______
Total Paid $	

VISA OR MASTERCARD NUMBER: ________ ________ ________ ________ EXPIRATION ______/______

______________________________ PRINTED NAME OF CARD HOLDER (REQUIRED)

______________________________ AUTHORIZED SIGNATURE (REQUIRED)

Credit Card company service fee of 3.04% will be added to the total

FOR OFFICE USE ONLY:		
AMOUNT: ________	SERVICE FEE: ________	TOTAL CHARGED ________