



MISSISSIPPI STATE DEPARTMENT OF HEALTH

LATE RENEWAL APPLICATION
CORRECT AND UPDATE ALL INFORMATION

PERSONAL INFORMATION:

Regular DT

Name: License #: DOB:
Address: County: Phone:
City, State, Zip Code: Email Address:

EMPLOYER INFORMATION

Name:
Address: County: Phone:
City, State, Zip Code:

- 1. Have you been convicted of any violations of law... YES NO
2. Have any criminal or civil lawsuits been filed... YES NO
3. Has any license been encumbered in any way... YES NO

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

(Applicant's Signature) (Date Signed)

- HAVE YOU: 1. REVIEWED THE ABOVE INFORMATION AND ANSWERED THE QUESTIONS
2. COMPLETED ALL FIELDS
3. SIGNED AND DATED THE RENEWAL APPLICATION
4. ENCLOSED THE \$100.00 RENEWAL FEE PLUS THE \$200.00 REINSTATEMENT FEE FOR A TOTAL OF \$300.00
5. NOTE: REGISTERED DIETITIANS ENCLOSE A CURRENT, SIGNED COPY OF CDR CARD
NON-REGISTERED DIETITIANS ENCLOSE PROOF OF CONTINUING EDUCATION

MAIL TO: MISSISSIPPI STATE DEPARTMENT OF HEALTH
PROFESSIONAL LICENSURE - DIETITIANS
PO BOX 1700
JACKSON, MS 39215-1700



MISSISSIPPI STATE DEPARTMENT OF HEALTH

LATE RENEWAL APPLICATION
CORRECT AND UPDATE ALL INFORMATION

PERSONAL INFORMATION:

Provisional DT

Name: License #: DOB:
Address: County: Phone:
City, State, Zip Code:

EMPLOYER INFORMATION

Name:
Supervisor Name: Supervisor License #:
Address: County: Phone:
City, State, Zip Code:

- 1. Have you been convicted of any violations of law... YES NO
2. Have any criminal or civil lawsuits been filed... YES NO
3. Has any license been encumbered in any way... YES NO

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

(Applicant's Signature) (Date Signed)

- HAVE YOU: 1. REVIEWED THE ABOVE INFORMATION AND ANSWERED THE QUESTIONS
2. COMPLETED ALL FIELDS
3. SIGNED AND DATED THE RENEWAL APPLICATION
4. ENCLOSED THE \$50.00 RENEWAL FEE PLUS THE \$200.00 REINSTATEMENT FEE FOR A TOTAL OF \$250.00
5. NOTE: IF UPGRADING, PLEASE ENCLOSE A CURRENT, SIGNED COPY OF CDR CARD

MAIL TO: MISSISSIPPI STATE DEPARTMENT OF HEALTH
PROFESSIONAL LICENSURE - DIETITIANS
PO BOX 1700
JACKSON, MS 39215-1700



MISSISSIPPI STATE DEPARTMENT OF HEALTH

Letter of Supervision

Licensee Name: _____

Supervisor Name: _____

Supervisor License #: _____

I hereby agree to supervise _____, as a provisional dietitian.

I acknowledge that the *Regulations Governing Licensure of Dietitians*, Rule 3.4.3, require that the listed supervisor of a provisional licensee conduct and record a written assessment on a monthly basis.

Supervisor Signature: _____

Date: _____