

RENEWAL APPLICATION FOR DIETITIAN LICENSURE

Your Dietitian license will expire February 28

Name _____
Address _____
City, State, Zip _____

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 United 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 determined 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 02/28/2022 but a \$50 late fee must be paid in addition to the \$135 renewal fee. After 04/01, 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 _____