

# Dietetics-Nutrition Form 4C

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000

## REPORT OF PLANNED WORK EXPERIENCE

**SECTION I: TO BE COMPLETED BY APPLICANT.** Complete Section I and make a copy for your records. Forward the original form to your supervisor to complete Section II. Associate Degree applicants must identify the supervisor's name from the list provided on Form 4. If your experience was completed in an internship program, Section II should be completed by the internship coordinator.

**Name:** Last   
First   
Middle   
**Social Security Number:**

**Mailing Address:** Line 1   
Line 2   
Line 3   
City   
State  Zip Code   
Country/Province   
**Birth Date:**  mo.  day  yr.

**Telephone/E-Mail:** Daytime Phone   
Area Code  Phone Number   
E-Mail Address (Please print clearly)

**Supervisor's/Internship Coordinator's Name:** \_\_\_\_\_

**Experience described below was obtained while employed by or as an internship sponsored by:**

**Organization Name:** \_\_\_\_\_

**Address:** Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Beginning \_\_\_\_ / \_\_\_\_ / \_\_\_\_ and ending \_\_\_\_ / \_\_\_\_ / \_\_\_\_ at \_\_\_\_\_ hours per week.  
mo. day yr. mo. day yr.

**Describe in the space below your dietetic/nutrition duties during your employment with the organization named above.**

I hereby certify that the work experience described above and the time claimed for that experience are true and accurate.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION II: TO BE COMPLETED BY SUPERVISOR OR INTERNSHIP COORDINATOR.** (Please type or print)

**INSTRUCTIONS TO SUPERVISOR OR INTERNSHIP COORDINATOR:**

1. Read the applicant's Report of Experience from page 1 of this form carefully and complete the following information.
2. Return this form directly to the Office of the Professions at the mailing address at the end of this form. This form will not be accepted if returned by the applicant.

**1** Print Full Name Of The Acceptable Dietitian Or Nutritionist Supervising The Planned Work Experience.

\_\_\_\_\_

*Last* *First* *Middle*

**2** Address

Line 1

Line 2

Line 3

City

State  Zip Code

Country/  
Province

**3** Telephone Number:

Daytime Phone

Area Code      Phone Number

E-Mail Address (Please print clearly)

**4** Are you registered in New York State as a certified Dietitian or Nutritionist?  Yes  No  Application submitted

If "Yes," certificate number \_\_\_\_\_

**5** Provide the name of any national dietetic or nutrition association in which you are currently registered or are a member and the date of registration/membership. **If you are not NYS certified, please attach a photocopy of your national registration/membership document.**

National Dietetic or Nutrition Association	
Date of current Registration/Membership	Type of Registration/Membership

**CERTIFICATION**

**I have read the applicant's description of this experience and find that description to be generally true and accurate. I hereby attest that this was a diverse and continuous work experience in dietetics and nutrition which reflected increased levels of professional growth.**

\_\_\_\_\_  
*Signature of Supervisor/Internship Coordinator*

\_\_\_\_\_  
*Date*

If you cannot sign the certification or disagree with any information presented by the applicant on this form, or wish to provide any other information for consideration by the Department relative to the applicant, please submit a separate letter of explanation with this form. If you do so, please identify applicant by full name and social security number in your letter and indicate that he/she is an applicant.

A separate letter is enclosed.  Yes  No

**Return Directly to:** New York State Education Department, Office of the Professions, Dietetics-Nutrition Unit, 89 Washington Avenue, Albany, NY 12234-1000.