Form 2 (PD)

Accreditation Council for Education in Nutrition and Dietetics

the accrediting agency for the Academy of Nutrition and Dietetics

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STATEMENT FOR PROVISIONAL LICENSURE PURPOSES ONLY*
SUPERVISED PRACTICE PROGRAM

Graduate Who Completed Supervised Practice:

____________________	____________________	____________________
Last Name	**First Name**	**Full Middle Name**

Supervised Practice Completed: ________________________________

The above-named applicant has satisfactorily completed a minimum of 1000 hours of supervised practice within a program accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND).

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name of Institution	**Original Signature of Program Director**
Address	**Program Director Name**
City/State/Zip	**Title**
Division/Department	**Date Form Signed by Program Director**

***Note this form is for use for provisional state licensure proposes only and does not verify program completion. This form cannot be used as a verification statement for eligibility for the Commission on Dietetic Registration (CDR) RDN exam.**