Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

CHIROPRACTIC EXAMINING BOARD

NUTRITIONAL COUNSELING CERTIFICATE OF PROFESSIONAL POSTGRADUATE EDUCATION

This form must be completed by the certifying body where your Board approved course was obtained.

APPLICANT: Complete this section and submit to certifying body for completion. Form must be returned directly from the certifying body to the Department.

Last Name: **First Name:** **MI:** **Former / Maiden Name(s):**

Address: (number/street) (city) (state) (zip code)

Application Number: **Date of Birth:** **Social Security Number** (voluntary-for school's use in locating your records):

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations. I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature: (If unable to provide a digital signature, print and sign form.) **Date:**

CERTIFIYING BODY: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Name of Institution/ Provider:

Address of Institution or Provider:

(number/street) (city) (state) (zip code)

DEGREE OR CERTIFICATE AWARDED (Check one of the **four** following boxes below, continued on next page.)

- ☐ Received a postgraduate degree in human nutrition, nutrition education, food and nutrition or dietetics conferred by a college or university that is accredited by an accrediting body listed as nationally recognized by the secretary of the federal department of education.
- ☐ Received diplomate status in human nutrition conferred by a college of chiropractic accredited by the Council on Chiropractic Education (CCE) or approved by the board or by an agency approved by the United States office of education or its successor.
- ☐ Received a postgraduate degree in human nutrition conferred by a foreign school determined to be equivalent to an accredited college of chiropractic by the CCE or approved by the board or another board approved accrediting agency, indicating that the applicant has graduated from a program that is substantially equivalent to a postgraduate or diplomate program under Wis. Admin. Code § Chir 12.02(1)(c)1. or 2.

Continued on next page.

Wisconsin Department of Safety and Professional Services

Institution/Provider completion, continued.

☐ Received a degree from or otherwise successfully completed a postgraduate program after December 1, 2006 consisting of a minimum of 48 hours in human nutrition that is approved by the board as provided in Wis. Admin. Code § Chir 12.03, after December 1, 2006. Provide date of postgraduate program completion: ☐☐ / ☐☐ / ☐☐☐☐ .

Date Diploma/Certificate Issued: ☐☐ / ☐☐ / ☐☐☐☐

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Dean or Department Head
(If unable to provide a digital signature, please print and sign form.)

☐☐ / ☐☐ / ☐☐☐☐
Date

Printed Name

☐☐☐-☐☐☐-☐☐☐☐
Ext ☐☐☐☐
Phone

Title