



Dear Certificant:

It is time to recertify for next year. Please complete the form below.

Attach the following items to this completed form:

1. Copy of transcript(s) showing **12 CE hours of nutrition** continuing education **from an accredited institution** or validation of having completed one of the other criteria (See Bylaws Article X at www.cbcn.us.)
2. Pay the recertification fee of \$125.00 by check, money order, PayPal or credit card)

Send all items to: **CBCN**  
**c/o Dr. Bill Rice**  
**4360 Northlake Blvd. #209**  
**Palm Beach Gardens, FL 33410**

**FAX: 561.370.6214**

**MUST BE RECEIVED BY DECEMBER 31<sup>st</sup>**

Certificants who fail to recertify by December 31<sup>st</sup> will have penalty fees assessed and will have to complete 12 additional hours of continuing education within 6 months to reinstate. If not completed by June 30<sup>th</sup>, they will be suspended. Timely renewal will prevent time and cost of additional CE hours to the certificant and the cost of reminder mailings to the CBCN. Your prompt renewal is much appreciated.

Please TYPE or PRINT clearly

Check here IF any data has changed in the past year

Name \_\_\_\_\_ Cell Number \_\_\_\_\_

E-Mail \_\_\_\_\_ Status:  Active  Retired

Office Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

Website: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Are you an ACA member?  Yes  No Are you a member of the ACA Council on Nutrition?  Yes  No

What information do you want listed on our website:  Phone  Fax  Email  Website

Please check yes or no to each of the following questions:

If there is a yes response, describe the circumstances on a separate sheet of paper. Answering yes to any question does not necessarily disqualify you from recertification. The information is sought as part of the overall credentialing process and all information will be kept confidential as provided by laws of the United States.

1. Have you been convicted of a felony in the past year?  Yes  No
2. Has your license to practice in any state or country been revoked, suspended, or otherwise limited in the past year?  Yes  No
3. Do you currently use drugs or alcohol to the point that it might affect your ability to practice?  Yes  No

I have met the requirements for recertification per the CBCN bylaws.

I have attached certificates / transcripts or included other criteria for recertification.

I am including a check or money order made out to CBCN or online (see above).

I have read the 12 articles and have the list available for audit.

I attest the information provided is true and accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

For CBCN use ONLY:  PD  CE  QB  AC  GM  Date \_\_\_\_\_ Init \_\_\_\_\_