Certified Nutrition Professional

CNP Supervised Practice Hours Guidelines & Approval Form

Those wishing to earn the title, "Certified Nutrition Professional" must demonstrate the successful completion of 1,200 Supervised Practice Hours.

Special Note: Those who have been in clinical nutrition practice for a minimum of five (5) years may be "grandfathered" in by providing the following:

- Evidence of completion of 1,500 combined Direct & Indirect Contact Hours (must be a minimum of 750 Direct contact hours; may consist exclusively of Direct contact hours) – for more information regarding contact hours, please see "Contact Hours Documentation Form."
- Two (2) additional professional letters of reference

Supervisor Credentials must consist of one or more of the following with a minimum of three (3) full-time years of clinical experience in nutrition care:

- Certified Nutrition Professional;
- Masters of Science or Doctoral Degree in nutrition or nutrition-related field of study (state licensed or certified); or
- Other licensed healthcare professional whose scope of practice legally includes the dispensation of nutrition education/counseling services (For example: Chiropractors, Nurses, Medical Doctors, Naturopathic Doctors).

Types of Supervised Practice Hours:

- Nutrition services, must include the following:
  - assessment
  - education, counseling, or management
  - monitoring or evaluation
- Not all experiences must take place within the same setting or under the same supervisor

The Supervisor must:

- Sign the Practice Supervisor Approval Form
- Meet with the candidate a minimum of twice monthly
- Provide written & signed confirmation of completion of the supervised practice hours

The Candidate must:

- Obtain approval of the Supervisor via this Practice Supervisor Approval Form
- Upon completion of hours, submit the Supervised Practice Hours Documentation Form for approval by the HNCB

CNP Supervised Practice Hours Form

Date	Number of Supervised Hours	Brief Description of Work Performed

Candidate's Name (print): _____ Total Number of Hours:_____

Supervisor Signature: _____

Practice Supervisor Approval Form

Please type or print in ink. All information must be provided.

Date: _____

Candidate Information

Name: _____

Email address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____

❑ I have contacted the person whose name appears below, and he/she has agreed to supervise my nutrition practice according to the guidelines set forth in the Supervised Practice Hours Guidelines.

Candidate Signature (required): _____

Supervisor Information

Supervisor Name: _____

Credentials: _____

Email address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____

❑ I agree to supervise the above named individual in the practice of Nutrition services, including assessment, education, counseling, management, monitoring, and evaluation of clients and to meet with said individual at least twice monthly regarding this practice until requirements are fulfilled.

Supervisor Signature (required): _____