



KENTUCKY BOARD OF LICENSED DIABETES EDUCATORS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street, Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 892.4253 | Fax: (502) 564.4818 | Website: bde.ky.gov | Email: lde@ky.gov

APPLICATION FOR LICENSURE GENERAL APPLICANT INFORMATION

You must include the non-refundable application fee of \$50.00 (fifty dollars) made payable by check or money order and made payable to the "Kentucky State Treasurer" with this application. The application will not be processed if the payment is not included. **NOTE:** The supervisor must be a Master Licensed Diabetes Educator or Licensed Diabetes Educator. Please print or type this application and mail the completed application and the to the address above. You **MUST** sign the applicant affidavit on Page 3.

Licensing Options (check one):

- ☐ **Master – (CDE/BC-ADM). You must include:**
- Certified Diabetes Educator (CDE) or Board Certified in Advanced Diabetes Management (BC-ADM)
 - (Attach copy of proof of certification as a CDE or BD-ADM. **DO NOT** complete Parts 2 & 3 of this application.
- ☐ **Licensed - You must include:**
- A completed **Diabetes Educator Apprentice Assessment (Post-Learning), Form DPL-BDE-02.**
 - A completed **Supervised Work Experience Report, Form DPL-BDE-03.**
 - **Attach certified copy of course completion** for the credentialing program of the American Association of Diabetes Educators or the National Certification Board for Diabetes Educators, or the ADCES Core Concepts Course *or* an equivalent program that has been approved by the Board. **YOU MUST** complete Part 2 & 3 of this application.

PART 1:

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
Telephone Number:	Email Address:	D.O.B.	SSN (Last 4):
Present Place of Employment Telephone Number:		Present Place of Employment E-mail Address:	

GENERAL QUESTIONS

Please answer each of the following questions by putting a check (a) in the appropriate box on the right.

- You must answer each question with a "Yes" or "No" or "Not Applicable" ("N/A") if this option is provided. No other response is acceptable.
- All "Yes" answers **MUST** be explained in detail in a separate SIGNED and NOTARIZED affidavit.
- Applicants should be aware that answering "Yes" to some questions may necessitate special screening procedures by the board.
- Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

1. Have you ever had any application for any professional license denied by any licensing authority?	☐ YES	☐ NO
2. Have you ever been denied the privilege of taking an examination required for any professional licensure?	☐ YES	☐ NO
3. Do you currently hold another professional license or credential? If yes, please list:	☐ YES	☐ NO
4. Have you ever been dropped, suspended, placed on probation, expelled, or requested to resign from any post-secondary educational program in which you were enrolled, for reasons in whole or in part, unrelated to grades?	☐ YES	☐ NO



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5. Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any professional training program prior to completing the training, for reasons in whole or in part, unrelated to grades?	☐ YES	☐ NO
6. Have you ever violated or been formally charged with a violation of the honor code of any educational facility?	☐ YES	☐ NO
7. Have you ever voluntarily surrendered any other health professional license or registration, allowed it to lapse, or had a limited license or registration issued by any health licensing authority? *	☐ YES	☐ NO
8. Have you ever had any other professional license revoked or have you ever been the subject of disciplinary action by any health professional licensing agency, including the refusal to grant, or had action to revoke, suspend, condition, limit, restrict or qualify a professional license in any way?	☐ YES	☐ NO
9. To your knowledge have any complaints ever been filed against you with any health care licensing agency, which remain unresolved or pending?	☐ YES	☐ NO
10. Have you ever been convicted, pled guilty, or pled nolo contendere (no contest) to a felony (or any criminal) conviction?	☐ YES	☐ NO
11. Have you ever been named as a defendant to a civil suit related to your profession (i.e., malpractice) which has not been previously reported to the board?	☐ YES	☐ NO
12. At any time in the last five years have you on a regular or occasional basis engaged in the illegal use of any controlled substance?	☐ YES	☐ NO
13. If yes to the question immediately above, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not illegally engaging in the use of controlled substances?	☐ YES	☐ NO ☐ N/A
14. Are you now or have you in the last five (5) years been addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?	☐ YES	☐ NO
15. Are you now being treated or have you in the last five (5) years been treated for a drug or alcohol addiction or participated in a rehabilitation program?	☐ YES	☐ NO

PART 2:

WORK EXPERIENCE

(Make additional copies as necessary)

Applicant Information:

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:

Institution Information:

Name of Institution:			
Mailing Address: Street	City:	State:	Zip Code:
Job Title:			

DPL-BDE-01
Rev. July 2025
KRS 309.331(1), 309.334(2)(a)
201 KAR 45:110



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Department:

Name of Immediate Supervisor:

Title of Immediate Supervisor:

Employment Questions:

Employment Status:

☐ YES, I am currently employed/self-employed in this position ☐ NO, I am NOT currently employed/self-employed in this position

Employment Dates:

FROM month _____ day _____ year _____ TO month _____ day _____ year _____.

For this job, I am claiming _____ hours per week in diabetes education. **DO NOT report hours as a range.**

I am claiming a **total of** _____ **hours** in diabetes self-management education for the employment dates listed above.

Practice Setting (check one only):

☐ Hospital Inpatient Only ☐ Physician's Office ☐ Hospital Outpatient Only ☐ Community/Public Health Agency
☐ Both Hospital Inpatient/Outpatient ☐ Self-Employed/Private Practice ☐ Home Health Agency ☐ Other(specify)

If you answered "Other", provide a description of the setting. Use a separate sheet of paper if necessary and attach to application.

Delivery method for diabetes self-management training that you provide(d) in this job (check one only):

☐ Face to face only ☐ Electronic only (e.g., telephone, internet) ☐ Face to face and electronic



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SUPERVISOR AFFIDAVIT

I am currently a licensed diabetes educator or master licensed diabetes educator, and I have served as supervisor to the applicant. I have reviewed the work experience portion of this application and attest that I meet the requirements to be a supervisor as set out in 201 KAR 45:110 and that to the best of my knowledge the applicant's work experience is accurate, complete and truthful. (Make additional copies as necessary).

Signature (Required) :

Date:

Title:

Department:

Institution:

Address:

City:

State:

Zip code:

Daytime Telephone (include area code):

Email Address:

PART 3:

SUPERVISION LOG PAGE

A minimum of 750 hours of work experience as an apprentice diabetes educator under a supervisor within the last five years, with 250 of those hours being obtained within the last year preceding licensure application, are required.

"Supervisor" means a "licensed diabetes educator" in good standing as defined by KRS 309.325(3) or a master licensed diabetes educator in good standing as defined in KRS 309.325(6).

Clinical Supervisor's Name:

KBLDE License #:

Professional Credentials:

Signature:

Number of Hours of Supervised Work Experience since last renewal: _____ Dates Obtained: _____

Telephone Number (Days only):

Additional Supervisor (if applicable):

Clinical Supervisor's Name:

KBLDE License #:

Professional Credentials:



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Signature: _____

Number of Hours of Supervised Work Experience since last renewal: _____ Dates Obtained: _____

Telephone Number (Days only): _____

Additional Supervisor (if applicable):

Clinical Supervisor's Name: _____

KBLDE License #: _____

Professional Credentials: _____

Signature: _____

Number of Hours of Supervised Work Experience since last renewal: _____ Dates Obtained: _____

Telephone Number (Days only): _____

(All applicants shall complete the Applicant Affidavit.)

APPLICANT AFFIDAVIT

I do hereby certify that under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that should an investigation at any time disclose any misrepresentation or falsification, my application could be rejected, or my license revoked by the Board.

Applicant's Signature

Date