



# SUB-CONTRACTOR APPLICATION

Please complete this form and submit it to Nutrition Advantage along with your resume or CV. Someone will be in contact with you shortly.

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**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHONE** \_\_\_\_\_ **CELL** \_\_\_\_\_

**FAX** \_\_\_\_\_ **OTHER** \_\_\_\_\_

**EMAIL** \_\_\_\_\_

**WEBSITE** \_\_\_\_\_

**RD REGISTRATION #** \_\_\_\_\_

**SOCIAL SECURITY #** \_\_\_\_\_

**LICENSE #/STATE** \_\_\_\_\_

**DO YOU HAVE PROFESSIONAL LIABILITY INSURANCE?**    **YES**            **NO**

**MAY WE CONDUCT A CRIMINAL BACKGROUND CHECK?**    **YES**            **NO**

**IS YOUR CDR STATUS CURRENT?**                            **YES**            **NO**

**HAVE YOU EVER WORKED AS A CONSULTANT?**            **YES**            **NO**

**WHEN ARE YOU AVAILABLE TO START CONSULTING?** \_\_\_\_\_

WHAT DAYS CAN YOU WORK? \_\_\_\_\_

HOW MANY HOURS CAN YOU WORK? \_\_\_\_\_

HOW MANY MILES ARE YOU WILLING TO TRAVEL? \_\_\_\_\_

CHECK ALL AREAS OF NUTRITION CARE THAT YOU HAVE EXPERIENCE **AND**  
CAN WORK INDEPENDENTLY

- |   |  |
|---|--|
| <input type="checkbox"/> ADOLESCENT                 | <input type="checkbox"/> HOSPICE                   |
| <input type="checkbox"/> AIDS                       | <input type="checkbox"/> IMMUNE DISORDERS          |
| <input type="checkbox"/> AUTISM                     | <input type="checkbox"/> NEONATOLOGY               |
| <input type="checkbox"/> ALLERGY                    | <input type="checkbox"/> NUTRITION SUPPORT         |
| <input type="checkbox"/> BEHAVIOR MODIFICATION      | <input type="checkbox"/> ADULTS                    |
| <input type="checkbox"/> BREASTFEEDING              | <input type="checkbox"/> PEDIATRICS                |
| <input type="checkbox"/> CANCER                     | <input type="checkbox"/> PEDIATRICS                |
| <input type="checkbox"/> CARDIOVASCULAR             | <input type="checkbox"/> PHARMACOLOGY              |
| <input type="checkbox"/> CHEMICAL DEPENDENCY        | <input type="checkbox"/> PREGNANCY/FERTILITY       |
| <input type="checkbox"/> COPD/RESP. FAILURE         | <input type="checkbox"/> PSYCHIATRY                |
| <input type="checkbox"/> CORPORATE PROGRAMS         | <input type="checkbox"/> PUBLISHING                |
| <input type="checkbox"/> CRITICAL CARE              | <input type="checkbox"/> RECIPE DEVELOPMENT        |
| <input type="checkbox"/> DENTAL                     | <input type="checkbox"/> REHABILITATION - PHYSICAL |
| <input type="checkbox"/> DERMATOLOGY                | <input type="checkbox"/> RENAL                     |
| <input type="checkbox"/> DEVELOPMENTAL DISABILITIES | <input type="checkbox"/> SCHOOL FOOD SERVICE       |
| <input type="checkbox"/> DIABETES                   | <input type="checkbox"/> SPORTS NUTRITION          |
| <input type="checkbox"/> EATING DISORDERS           | <input type="checkbox"/> VEGETARIANISM             |
| <input type="checkbox"/> FITNESS                    | <input type="checkbox"/> VITAMINS/MINERALS         |
| <input type="checkbox"/> FOOD-DRUG INTERACTIONS     | <input type="checkbox"/> WEIGHT CONTROL            |
| <input type="checkbox"/> GESTATIONAL DIABETES       | <input type="checkbox"/> WELLNESS                  |
| <input type="checkbox"/> GRANT WRITING              | <input type="checkbox"/> OTHER – PLEASE SPECIFY    |
| <input type="checkbox"/> GERONTOLOGY                | _____  |
| <input type="checkbox"/> GI DISORDERS               | _____  |
| <input type="checkbox"/> HERBAL MEDICINE            |  |
| <input type="checkbox"/> HOME HEALTH                |  |

BEST TIME/METHOD TO CONTACT YOU? \_\_\_\_\_

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THANK YOU FOR COMPLETING THIS INFORMATION