



Department of Commerce
Office of Professional Licensure Review

2026 Periodic Review

Dietitians

Published September 2026

Executive Summary

Dietitians are healthcare practitioners who specialize in using food and nutrition to improve health outcomes for individuals and communities. Dietitians are the primary providers of medical nutrition therapy (MNT), which “involves the use of individualized nutrition interventions to treat or manage medical conditions and diseases ... in various practice settings, such as hospitals, physician offices, private practice and other health care facilities”.¹

Almost all U.S. jurisdictions license or certify dietitians. The requirements for licensure or certification are essentially identical across states, while scope of practice differs. Many states (29) protect a dietitian’s scope of practice. Approximately half of those (13 states) define scope narrowly to cover MNT only,² and approximately half define scope more broadly. Utah is one of 17 states with a voluntary certification for dietitians which protects the title “dietitian” and requires proof of credentials.

Many states (24) also regulate a national nutritionist qualification, the Certified Nutrition Specialist (CNS).

Regulatory Model Recommendation: Maintain voluntary certification for dietitians

- OPLR views the consequences of poor or untrained MNT as typically moderate and reversible. However, the potential for harm inherent to MNT is exacerbated by the vulnerability of patients and downstream implications if untrained care is provided. Regardless, there is low evidence justifying a need for additional regulation.
- Dietitians largely operate with employer and private oversight, although a small market exists for private practice, which could be self-pay.
- The nutrition and diet information marketplace is crowded and likely highly confusing to consumers. State certification helps provide a signal of competence.

Recommended Regulatory Adjustments: None

Given indications of safe practice and few concerns regarding patient access, OPLR does not recommend significant adjustments to the current regulatory model.

Additional Recommendations: Expand pathways to voluntary certification by accepting the CNS exam

- Twenty-four other states accept the CNS exam, either as a separate or as a combined certification. OPLR prefers a combined, newly-named certification.
- This additional pathway will reduce barriers to entry into the field of dietetics and nutrition by allowing those with a CNS to meaningfully work in Utah, increasing competition and choice for Utah employers, consumers, and patients.

¹ Academy of Nutrition and Dietetics, "Medical Nutrition Therapy."

² These states generally define MNT as nutrition care services for the explicit purpose of managing or treating a diagnosed medical condition.

Context

Consistent with its legislative mandate, the Office of Professional Licensure Review (OPLR) reviewed Utah's regulatory laws for dietitians. The review evaluated how well current regulations:

1. Protect the public from present and consequential physical and financial harm
2. Balance public and practitioner access to the occupation
3. Limit the economic impact of regulation on consumers, practitioners, and the state³

OPLR's research for this review included analysis of Utah's current laws and rules, licensing and complaint data from the Division of Professional Licensing (DOPL), academic literature, health workforce data, and laws and policies in other states. OPLR also conducted interviews with practitioners, industry representatives, business owners, employers, educators, and other subject matter experts. See Appendix 1.1 for more information.

Background

Profession Overview

Dietitians are healthcare practitioners who specialize in using food and nutrition to improve health outcomes for individuals and communities. Dietitians practice in a wide range of settings and provide an array of services. They work in clinical healthcare, business and industry, public health systems, education, research, and food service institutions.^{4,5} Depending on the setting, dietitians may give advice on nutrition and healthy eating habits, develop meal plans, conduct research, or provide medical nutrition therapy (MNT).

Dietitians are the primary providers of MNT, which "involves the use of individualized nutrition interventions to treat or manage medical conditions and diseases ... in various practice settings, such as hospitals, physician offices, private practice and other health care facilities".⁶ Dietitians providing MNT evaluate an individual's acuity, nutrition status, and goals to develop a nutritional care plan, which could include nutrition counseling, diet alteration, or specifying certain nutrients, including through intravenous or tube feeding. Dietitians provide MNT to individuals of all ages with a range of conditions, such as malnutrition, eating disorders, diabetes, cancer, cardiovascular disease, chronic kidney disease, and food allergies and intolerances.⁷

³ Utah Code § 13-1b.

⁴ Dietitians report working in the following settings: 24% acute care in-patient, 22% ambulatory/outpatient care, 8% social services or public health, 6% private practice, 6% long term care, 5% acute care out-patient, 35% other (e.g., academic medical center, school nutrition, home health, contract food management company). Academy of Nutrition and Dietetics, 2024 Compensation and Benefits Survey.

⁵ This is not a comprehensive list of settings. For more information on settings and scope of practice, see Commission on Dietetic Registration, Revised 2024 Scope and Standards.

⁶ Academy of Nutrition and Dietetics, "Medical Nutrition Therapy."

⁷ For a more complete list of medical conditions that benefit from MNT, see Academy of Nutrition and Dietetics, "Nutrition Care Manual."

Dietitians hold a Registered Dietitian (RD) certification.⁸ The RD is an industry-standard national certification offered by the Commission on Dietetic Registration (CDR) and requires applicants to meet certain educational and experiential requirements, such as a master's degree and 1,000 hours of supervised practice.

Dietitians are not the only practitioners in this field; nutritionists also specialize in using food and nutrition to improve client health. Although their scopes of practice can be similar, depending on state law, the education, approach, and practice setting of these two groups can differ substantially. The title “dietitian” and the designations “Registered Dietitian” (RD) and “Registered Dietitian Nutritionist” (RDN) are privately protected and often state protected,⁹ whereas the title “nutritionist” is not trademarked, although many states recognize a national qualification, the Certified Nutrition Specialist (CNS) certification via licensure or certification.^{10,11} The term “nutritionist” can encompass a broader set of providers, including individuals with no formal nutrition education or expertise. Hospitals and other clinical settings almost exclusively hire only state-regulated dietitians, and insurance only reimburses MNT provided by dietitians unless a state formally recognizes other providers.^{12,13} Therefore, nutritionists, who may or may not hold a CNS qualification, tend to work in a range of non-acute, outpatient, private practice, and health and wellness coaching settings.

Profession in Utah

There are 1,665 certified dietitians in Utah.¹⁴ To achieve certification in the state, a dietitian must hold at least a bachelor's degree in a relevant field from an accredited college,¹⁵ complete an internship or pre-planned professional experience in a dietetic program under the supervision of a certified dietitian, and pass the Registration Examination for Dietitians.¹⁶ Although Utah law does not explicitly require a postgraduate degree, all dietitians must now complete a postgraduate degree to sit for the Registration Examination.¹⁷

Utah regulates dietitians through voluntary certification. Utah law protects the title “dietitian,” which is stricter than a typical certification allowing a practitioner to say they are “state

⁸ The certification is also known as the “Registered Dietitian Nutritionist” (RDN).

⁹ The title “dietitian” is protected in all but one state, and the RD and RDN are trademarked designations owned by the Academy of Nutrition and Dietetics and require education, experience, and an exam to obtain.

¹⁰ 20 states protect the title per OPLR Policy Scan; see [Appendix 1.2](#).

¹¹ A CNS has similar, although not identical, education and experience to an RD. See later discussion in this report.

¹² For example, CMS requires medical nutrition therapy providers to either be state authorized or meet specific criteria in states that do not license (e.g., certification as an RD). 42 CFR § 410.134.

¹³ Reimbursement often requires state authorization, so nutritionists may successfully seek reimbursement in states that license or certify nutritionists.

¹⁴ DOPL Historic Licensing Data, retrieved October 2025.

¹⁵ Specifically, the degree must be conferred with a major course of study in the sciences of food, dietetics, food systems management, or an equivalent major course of study.

¹⁶ The Registration Examination for Dietitians is administered by the Commission on Dietetic Registration (CDR).

¹⁷ Commission on Dietetic Registration, “Degree Requirement for Registration Examination.”

certified”.¹⁸ However, Utah does not protect the scope of practice for dietitians, allowing others to provide food and nutrition-related services within the state.

Approaches in Other Jurisdictions

Most U.S. jurisdictions (47 states and D.C.) license or certify dietitians. Of the four that do not, only one has no regulation whatsoever, while the other three protect the title “dietitian” but do not require confirmation of credentials by the state. Over half of states (29) license dietitians, regulating both title and scope of practice. Seventeen states, including Utah, have a voluntary certification for dietitians, protecting only the title but requiring proof of credentials.

The requirements for licensure or certification are essentially identical across all states, as nearly every state requires dietitians to pass the RD exam administered by the CDR.¹⁹ To sit for the exam, an individual must have graduated from a dietetics program accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND), hold a graduate degree, and attain 1,000 hours of supervised practice experience. As a result, a master’s degree and supervised practice experience are the de facto educational requirements to be a licensed or certified dietitian.²⁰

Although the requirements to be licensed are largely standardized, the scope of practice varies significantly among the 29 states that license dietitians. Thirteen states limit the scope of practice to the provision of MNT, allowing anyone else to offer non-medical nutrition and food counseling.²¹ Fifteen states define the scope of practice more broadly to include nutrition assessment and nutrition counseling, the majority of which exempt individuals providing general nutrition advice.

Almost half of states (24) also accept the CNS exam for licensure or certification. Sitting for this exam similarly requires a master’s degree and supervised practice experience, although master’s programs do not need to meet specific programmatic accreditation requirements so long as they are within a certain set of fields related to nutrition science.²² Eight states consider

¹⁸ For example, Utah regulates music therapy through voluntary certification but only protects the titles “certified music therapist” or “state certified music therapist”, thereby allowing anyone to call themselves the generalized term “music therapist”. UCA 58-84.

¹⁹ The 3 states with title protection but no certification may not require this exam; OPLR could not find information for Virginia or California, and Colorado only requires 900 hours of work experience and a relevant degree.

²⁰ Many states, including Utah, statutorily accept a bachelor’s or graduate degree. However, by requiring the RD exam, all states implicitly require a master’s for new applicants.

²¹ These states generally define MNT as nutrition care services for the explicit purpose of managing or treating a medical condition. Other individuals can provide personalized nutrition counseling as long as they are not claiming to treat a diagnosed condition.

²² The American Nutrition Association requires individuals to meet either of the following degree requirements: 1) Master of Science or Doctoral degree in a field of nutrition or a related field (including, but not limited to Public Health, Health Science, Biochemistry, Nursing, Physician’s Assistant, Dietetics) from a United States regionally/institutionally accredited college or university, or its foreign equivalent; or 2) Doctoral degree in a field of clinical healthcare (including, but not limited to, DC, DDS, OD, Doctor of Nursing, ND, PharmD) from a United States regionally accredited college or university, or its foreign equivalent. American Nutrition Association, “Nutritionists Health Professionals.”

the RDN and CNS equivalent pathways to the same license or certification, while the other 16 states recognize each qualification under separate licenses/certifications.

Regulatory Model Assessment & Recommendation

Framework

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g., license, registry, no regulation), OPLR developed a framework that incorporates its statutory review criteria.²³ Appropriate models are determined principally by an evaluation of the potential for harm and related factors that may aggravate or mitigate the potential for harm. These factors include the availability of consumer choice, vulnerability of patients, and independence of practice. See [Appendix 2.1](#) for more information.

Potential for harm

The potential for harm in dietetics results primarily from the provision of MNT, as this practice involves treating and managing medical disorders using nutrition. OPLR views the consequences of poor or untrained MNT as typically limited in severity given a lack of data on adverse outcomes.²⁴ However, the need for dietary assistance for acute and complex medical conditions is commonplace and can be critical in certain instances. Dietitians, especially those in clinical settings, treat highly physically and mentally vulnerable patients. Dietitians are also largely responsible for the nutritional health of patients who require non-oral feeding (e.g., feeding tubes, IV) or special, prescribed diets. In certain hospitals, dietitians may even place feeding tubes. For these acute patients, maintaining proper nutrition is important in addressing disease progression and can be crucial for survival in rare instances.

The potential for harm inherent to MNT is exacerbated by the downstream implications of untrained care. In non-acute cases, immediate, life-threatening, and irreversible damage is highly unlikely. However, incompetent MNT could exacerbate an individual's condition or result in a patient needing further medical attention. For example, dietitians treat individuals with conditions such as diabetes or disordered eating, where poor or negligent treatment may exacerbate the existing disorder and result in hospitalization.

Related harm factors

Dietitians operate with varying degrees of oversight. The majority of dietitians work in settings with sophisticated employer oversight, such as hospital systems and acute settings, and

²³ Among other criteria, OPLR is required to evaluate “whether the regulation of the occupation is necessary to address a present, recognizable, and significant harm to the health, safety, or financial welfare of the public” and consider “potentially less burdensome alternatives to the... existing regulation”. Utah Code § 13-1b-302.

²⁴ See the discussion on page 6 for more information on the analyses completed to reach this conclusion. In the absence of any data, OPLR considers the potential for harm by contemplating the consequences of an untrained yet well-meaning individual performing a given task. For patients not in critical condition, it is unlikely for dietary counseling, even given to a patient with a chronic condition, to be acutely or permanently harmed.

collaborate on patient care.²⁵ Dietitians treating the highest acuity patients work in these settings, which helps to mitigate potential for harm. Large healthcare institutions require their providers to meet a high standard of competency,²⁶ and there are other healthcare providers monitoring the patient and their treatment.

Employer oversight is not universal. A small percentage of dietitians (8%) report being self-employed,²⁷ and thus have lower levels of oversight. Additionally, it is becoming more common for dietitians to offer services independently via telehealth. This could be as an independent practitioner or a contractor with an online dietetics service such as NourishedRx, although online services may offer patient guardrails similar to traditional employers.²⁸ Online reviews and private certifications convey information regarding provider competency. However, it may be difficult for consumers to discern the difference between various private certifications in this field, which can offer much lower levels of training than RDN or CNS. Oversight by insurers allays some of this concern, because insurers often only reimburse MNT providers who are registered dietitians or are otherwise authorized by the state, such as CNS practitioners.²⁹ Still, some patients may opt for self-pay.

In these non-acute settings, patient or client cooperation with treatment is a complicating factor and can contribute to health outcomes (be they positive or negative) separate from professional advice received from a dietitian. In this sense, the clients themselves bear significant responsibility for health outcomes, which lowers the need for rigorous state regulation.

For more detail on OPLR's analysis of dietitians according to the framework, see [Appendix 2.2](#).

Recommendation

OPLR concludes that voluntary certification (rather than full licensure with a protected scope of practice) is an appropriate model of regulation for dietitians.

Importantly, OPLR found insufficient evidence connecting the provision of MNT to adverse patient outcomes.³⁰ The acute vulnerability of some patients establishes theoretical risk, but OPLR could not establish a strong enough link to patient harm to warrant either further regulation of dietitians or restricting MNT practices to certain individuals. To illustrate that harm has occurred in Utah, the Utah Academy of Nutrition and Dietetics (UAND) shared ten cases of

²⁵ According to one national survey, nearly ⅔ of dietitians surveyed reported the practice area of their primary position as clinical nutrition (includes acute-care inpatient, ambulatory, and acute-care outpatient). Academy of Nutrition and Dietetics, 2024 Compensation and Benefits Survey of Dietetics.

²⁶ CMS will only reimburse for care provided by a qualified nutrition professional (i.e. RD or CNS). 42 CFR § 410.134

²⁷ 2024 Academy of Nutrition and Dietetics, Compensation and Benefits Survey of the Dietetics Profession.

²⁸ Some online services may provide oversight similar to other employer types. For example, NourishedRx, a prominent provider of online dietetic services, requires their dietitians to be actively certified as RDs and has guidelines for exclusion based on a patient's disorders. They do not treat eating disorders nor any condition requiring parenteral nutrition. They also establish evidence-based clinical treatment guidelines for providers to follow. OPLR Stakeholder Series.

²⁹ OPLR could not find an example of a payor reimbursing for services not provided by a nutrition specialist authorized by the state.

³⁰ See [Appendix 2.3](#) for information on the analyses performed by OPLR.

harm resulting from MNT provided by both certified and uncertified individuals in the state. This data confirmed that nutrition advice can, in some circumstances, result in severe harm (e.g., a recommendation for an excessively high-protein diet caused liver failure in an otherwise healthy teenage boy) or worsen an existing condition.

However, regulating MNT would not address the majority of these cases. Six cases involved trainers or coaches providing advice to assist with general health, weight loss, or performance, not to directly treat a medical disorder (and are thus not categorized as MNT).³¹ The remaining four cases, which involved the provision of MNT, did not establish sufficient justification to warrant further regulation.³² Unable to substantiate whether a present, recognizable risk currently exists under the current regulatory structure, OPLR cannot recommend a regulatory structure that increases regulation by protecting the scope of practice. Other states, such as Colorado, have come to similar conclusions in their sunrise reviews of dietetic licensing.³³

Furthermore, OPLR contends that the potential for harm from providing MNT is mitigated by employer oversight in settings where the most vulnerable patients are treated, by consumers themselves, and by insurers, which require MNT to be provided by qualified professionals.

Voluntary certification serves to address the remaining risk posed by nutrition professionals in private-practice, self-pay settings, where consumers have full choice over their provider. There is potential for consumer confusion in a crowded field of food and nutrition information, and the downstream impact of poor MNT—especially for acute or medically complex patients—may cause harm. Voluntary certification assists consumers by signaling competency via state endorsement of credentials and protection of title which consumers may consider when choosing a provider, while still allowing a range of providers to offer food and nutrition services within the state.

Regulatory Model Adjustments & Recommendations

Framework

After determining an appropriate regulatory model, OPLR's framework also evaluates whether adjustments should be made within a recommended model to address any material and existing safety and access issues affecting the Utah public and practitioners. Regulatory model adjustments may include changing entry qualifications, the scope of practice, unprofessional or unlawful conduct, and/or supervision and independence provisions (see [Appendix 3.1](#)).

³¹ Two of these cases involved obese individuals attempting to lose weight. The dietetics industry considers this “medical weight loss” and within the definition of MNT. OPLR disagrees with this categorization as it would unreasonably broaden the definition of MNT to the entire weight loss industry.

³² These four cases illustrate that harm can occur due to the incompetent provision of MNT but do not establish consistent severity, or the frequency or likelihood of that harm, nor the necessity for higher regulation. Only two cases resulted in significant harm, one of which was an outlier case involving a disturbed and uncooperative patient. The other two cases could be addressed through existing regulation. These two other cases involved deceptive advertising (selling saline water as a cure for disease, false promises of supplement efficacy) and therefore could be addressed through the Division of Consumer Protection for violations of the Utah Consumer Sales Practices Act (CSPA).

³³ See [Appendix 2.3](#).

Safety Issues

OPLR found no evidence suggesting that dietitians in Utah are causing severe or systemic harm to the public, though data is limited. OPLR analyzed DOPL's complaint data and found that, of the nine substantiated dietitian-related complaints investigated between 2017 and 2024, only one was made against a practicing dietitian.³⁴ That case involved an expired certification and DOPL did not find evidence of any harm. The remaining complaints alleged unauthorized use of the title "dietitian." Practitioners and employers similarly relayed no concerns with the safety of practice by certified dietitians.³⁵ OPLR also consulted the Utah Division of Consumer Protection, which reported little concern regarding fraudulent dietitian claims.³⁶

Access Issues

Utah has an adequate supply of dietitians overall. The U.S. Health Resources and Services Administration's (HRSA) state-level modeling and forecasting estimates that Utah's supply of dietitians will not fall below 100% adequacy at any point between now and 2037.³⁷ The number of certified dietitians in Utah grew 7% on an annualized basis between 2014 and 2025, far above the growth in Utah's population.^{38,39} Utah's supply is comparatively robust, ranking 14th in the nation in the number of RDs per capita.⁴⁰ Utah also has four educational institutions offering accredited programs that graduate a combined ~75 students annually and provide the state with a modest yet continuous supply of dietitians.⁴¹ Furthermore, the Utah Legislature passed S.B. 317 in 2025, which establishes Utah as part of a national compact for dietitians and will likely increase the number of available practitioners in Utah via telehealth.⁴²

Employers and practitioners OPLR spoke with largely agreed that the demand was being met by supply, reporting reasonable wait times of a few days to a few weeks, depending on a patient's availability.⁴³ One prominent employer of dietitians in hospital-based, acute, and clinical settings did note some difficulty in hiring, particularly for dietitians with specialty experience or in rural areas, but overall hiring is reasonable. Stakeholders expressed a general view that any hiring challenges are likely due more to workforce preferences by dietitians rather than a lack of

³⁴ DOPL Complaint Data. See [Appendix 3.2](#) for more information on OPLR's use of this data and the limitations.

³⁵ OPLR Stakeholder Series.

³⁶ OPLR Stakeholder Series. They reported receiving few complaints regarding this topic.

³⁷ U.S. Health Resources and Services Administration, "Health Workforce Projections."

³⁸ In the same time period, Utah's population grew by ~1.8% on an annualized basis. OPLR used the annual Utah population estimates from the IBIS Query Builder using Kem C. Gardner Policy Institute Population Estimates. Utah Department of Health and Human Services, "Population Query Builder."

³⁹ DOPL Historic Licensing Data. See [Appendix 3.3](#) for more information on OPLR's use of this data. It should be noted that not all of these practitioners primarily practice from within Utah. 35% of licensees currently list out-of-state addresses on their license. This is not overly concerning because telehealth is a viable and common means of receiving dietetics treatment and services.

⁴⁰ Commission on Dietetic Registration, "Registration Statistics"; U.S. Census Bureau, "2025 Population Estimates."

⁴¹ OPLR Stakeholder Series.

⁴² Joining this compact enables licensed or certified dietitians to receive a compact license, thereby allowing that individual to practice in any state which is also a member of the compact without having to get a license in that state. The minimum number of states passed legislation to join the compact so that it can now be put into place.

⁴³ OPLR Stakeholder Series.

supply. Clinical work can be higher stress, with lower compensation and less flexible hours compared to working in other settings.^{44,45}

Individuals looking to enter the dietetics profession face moderate barriers to entry. Due to changes made by ACEND, the entry-level degree for dietitians recently moved from a bachelor's to a master's, imposing greater costs on individuals looking to enter the field.⁴⁶ Program costs in Utah range from about \$18,000 to about \$47,000⁴⁷ and dietitians have a median, full-time salary of about \$80,000.⁴⁸

Practitioners also noted issues with reimbursement. Although many plans cover dietetic services, some payers may restrict coverage to a narrow set of conditions or set a low cap on the number of visits.⁴⁹ Limited insurance reimbursement may be a particularly salient issue for dietitians, as CMS guidelines are comparatively restrictive.⁵⁰

Recommendation

OPLR does not recommend any significant adjustments to the current regulatory model for dietitians due to the lack of pressing concerns related to safety or access. However, OPLR recommends removing barriers to other similarly educated practitioners in this field by recognizing additional qualifications for certification (see below).

Additional Recommendations

Recommendation 1: Expand pathways to voluntary certification

OPLR recommends accepting the CNS credential as an alternative pathway to state certification. The CNS and RD/RDN share many similarities. Both industry certifications are accredited by the National Commission for Certifying Agencies (NCCA) and recognized by the U.S. Department of Labor as advanced nutrition credentials.⁵¹ To attain either certification, an applicant must have a master's degree from an accredited institution of higher education,

⁴⁴ OPLR Stakeholder Series.

⁴⁵ RDNs working in acute-care/inpatient clinical roles report a lower median wage than all other practice areas except for community and public-health nutrition. Other practice areas included: clinical nutrition-ambulatory care, clinical nutrition-long term care, education and research, management and executive leadership, and consultation, business & industry, entrepreneurial. Academy of Nutrition and Dietetics, 2024 Compensation and Benefits Survey, exhibit 3.11.

⁴⁶ Costs have not increased for all students in Utah, as certain programs offered master's degrees before this mandate.

⁴⁷ Range is based on in-state tuition estimates from Brigham Young University, University of Utah, Utah State University, and Southern Utah University websites.

⁴⁸ Academy of Nutrition and Dietetics, 2024 Compensation and Benefits Survey. This is a national estimate, as no Utah-specific estimate exists. The Utah Department of Workforce Services and Bureau of Labor Statistics report salary amounts, but they combine dietitians and nutritionists into one group, which skews the estimates lower.

⁴⁹ OPLR Stakeholder Series.

⁵⁰ CMS only covers MNT for renal disease and diabetes, limited to 3 total hours the first year of treatment and two hours a year for subsequent years. CMS coverage for other out-patient therapies (physical, occupational, speech-language) is not as restrictive. CFR § 410.132, 410.59, 410.60, 410.62.

⁵¹ American Nutrition Association, "Become a CNS."

complete graduate-level education in nutrition, gain about 1,000 hours of supervised experience, and pass a psychometrically validated exam.

There are some differences between the two qualifications, but these are not significant enough to justify different treatment for purposes of state regulation. The RD/RDN credential requires programmatic accreditation for both the master's degree (which must be in dietetics) and clinical experience. A CNS credential accepts a wider variety of nutrition-related degrees (including professional healthcare degrees) and neither the graduate-level nutrition education nor supervised experience must meet programmatic accrediting standards. However, the degree to qualify for a CNS must still be issued by an accredited institution of higher education and the clinical experience must meet certain requirements and be supervised by an approved supervisor.⁵² The RD/RDN requires competence in a wider variety of nutrition roles, including as clinical dietitians in inpatient hospital settings, while the CNS credential requires competence in providing personalized nutrition therapy, typically in outpatient settings.⁵³

Accepting the CNS credential will reduce barriers to entry into the field of dietetics and nutrition by allowing those with a CNS to be reimbursed and meaningfully work in Utah, increasing competition and choice for Utah employers, consumers, and patients. Additionally, OPLR contends that both pathways signal competency, and it is anticompetitive for the State to recognize only one credential when multiple legitimate alternatives exist. Currently, CNS professionals generally cannot be reimbursed for providing MNT in Utah, because insurers commonly only reimburse providers who have received state authorization.⁵⁴ With fewer avenues for payment, these providers are disincentivized from working in Utah. Expanding the pathways to licensure may also improve public safety by creating another reliable signal in a confusing marketplace, which may help consumers avoid unqualified providers.

OPLR recommends a regulatory approach in which both pathways are recognized under the same certification. Eight states have adopted this model by broadly defining the education and experience requirements and accepting both the CNS and RD exams.⁵⁵ OPLR proposes either 1) accepting proof of CNS certification as qualifying for state certification or 2) broadening the requirement for professional experience and accepting the CNS exam. Option 1 carries less

⁵² The supervised clinical experience must be at least 1000 hours of supervised practice, with at least 200 hours in Personalized Nutrition Assessment and Interpretation, 200 hours in Personalized Nutrition Intervention, Education, Counseling, and Ongoing Care, and 200 hours in Personalized Nutrition Monitoring and Evaluation. A qualified supervisor is one who: 1) has held a CNS credential, RD with a master's or doctorate degree, or Doctorate of Clinical Nutrition for at least three years, 2) a minimum of 1500 client-facing practice hours, and 3) hold an LDN/LN license (or equivalent) in any U.S. state. American Nutrition Association, "Supervised Practice Experience Competencies."

⁵³ A CNS may still be qualified to perform MNT in a hospital setting or manage food systems, depending on their specific degree and experience. However, unlike RDs, certification does not require competency in those roles.

⁵⁴ For example, it is unlikely that those with a CNS can be reimbursed by CMS in Utah. CMS specifies that a provider of MNT must be "licensed or certified as a dietitian or nutrition professional by the State in which the services are performed". If a state does not have a license or certification, a qualified provider is one who: 1) holds a bachelor's degree or higher and has completed the academic requirements of an accredited program in nutrition or dietetics, and 2) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. A CNS may meet provider qualifications in those states who do not regulate the profession, but in states that do regulate it (like Utah), they must have state authorization. 42 CFR § 410.134

⁵⁵ OPLR Policy Scan. See [Appendix 4.1](#) for a detailed review of other state approaches. See [Appendix 1.2](#) for an overview of how OPLR conducts policy scans.

administrative burden, while Option 2 is similar to other state approaches. With respect to title, OPLR recommends changing the primary title of the act from “certified dietitian” to “certified dietitian-nutritionist” and protecting the titles “dietitian nutritionist,” “certified dietitian nutritionist,” and “state certified nutritionist,” along with existing protected titles.

An alternative option is to create a distinct “certified nutritionist” credential. Twelve other states have adopted this model.⁵⁶ OPLR does not recommend this approach as it increases the administrative burden without public benefit. To warrant separate certifications, there must be evidence that an individual confusing a CNS with an RDN may cause material harm and vice versa—in this case, there is not. Furthermore, the CNS and RD/RDN are private, protected certifications, and employers or patients can look to those trademarked titles to differentiate between the two when necessary. The State’s role is to regulate for safety—not to assist in marketing specific educational credentials via its regulation.

OPLR reviewed two other private credentials, the Diplomate, American Clinical Board of Nutrition (DACBN) certification offered by the American Clinical Board of Nutrition and the Certified Clinical Nutritionist (CCN) certification offered by Clinical Nutrition Certification Board. OPLR determined that neither signaled equivalent competency in the provision of medical nutrition therapy. The DACBN requires a doctorate in a healthcare field but vaguely defines the education and experience requirements and less than one-fifth of the exam covers nutrition interventions.⁵⁷ The CCN requires completion of an online study course, which is not accredited, and the therapeutic interventions on the CCN exam focus on homeopathy, phytotherapy, and herbology, not nutrition or diet.^{58,59}

OPLR notes that Utah participates in the Dietitian Licensure Compact, which now appears in the code of 18 states. A combined CNS and RD/RDN certification would not violate the terms of the compact and would not disallow Utah dietitian-nutritionists who use the RD/RDN pathway from full participation.⁶⁰ Further, it would not allow registered dietitian-nutritionists who used the CNS pathway to participate in this compact, as the compact commission has not approved this exam by rule. None of the states participating in the compact currently use a combined certification, and six route the CNS exam to a separate credential.

⁵⁶ OPLR Policy Scan.

⁵⁷ DACBN requires around 10 semester credit hours of “nutrition” but does not define what the education must include. It also requires one year of practice in nutrition but does not require this to be supervised nor does it detail what that experience must consist of. American Clinical Board of Nutrition, 2023 Candidate Handbook.

⁵⁸ Clinical Nutrition Certification Board, “Steps to Credentialing.”

⁵⁹ Clinical Nutrition Certification Board, Study Guide for the CCN Examination.

⁶⁰ Utah Code § 58-89-103(5)–(6) states that “[n]othing in this Compact shall affect the requirements established by a Member State for the issuance of a Single State License... At no point shall the Compact Commission have the power to define the requirements for the issuance of a Single State License to practice dietetics. The Member States shall retain sole jurisdiction over the provision of these requirements.”

Rule Review

In accordance with Utah Code § 13-1b-203(5), OPLR conducted an in-depth review of DOPL's dietetics rules, found in Utah Admin. Code R156-49.

The rule review covered potential rule changes needed to:

1. address specific rules that may be overly burdensome (e.g., for individuals seeking to practice a profession, or given the potential risk to public safety from a profession) or insufficient (e.g., to ensure safe practice);
2. address rules misaligned with statutory language;
3. clarify language, and correct references to statute or other rules; or
4. support OPLR's recommendations.

OPLR's review of R156-49 found:

1. OPLR did not find any overly burdensome or insufficient rules.
2. No rules misaligned with statutory language
3. There are five incorrect references to statute:
 - a. Utah Admin. Code R156-49-102(2) refers to Utah Code § 58-49-4(4), which has been superseded, and should refer to § 58-49-4(1)(c).
 - b. R156-49-102(3)&(4) refers to Utah Admin. Code R156-49-102(3) and (4) refers to Utah Code § 58-49-4(3), which has been superseded, and should refer to § 58-49-4(1)(b).
 - c. Utah Admin. Code R156-49-302 refers to 58-49-4(2),(3) Utah Code § 58-49-4(2), (3), and (4), which have been superseded, and should refer to § 58-49-4(1).
 - d. Utah Admin. Code R156-49-104 refers to Utah Admin. Code R156-1-107, which does not exist.
4. New rules regarding the alternative CNS pathway may need to be added.

Appendix

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1. Context

1.1 General Research Methodology

OPLR's methodology combines qualitative and quantitative methods with stakeholder engagement. Methods include:

- Analyzing data from workforce surveys administered by the Department of Professional Licensing (DOPL) as part of licensure renewal
- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities (e.g., DWS, BLS) as well as relevant industry associations (CDR, ANA)
- Reviewing academic literature and reports on a profession's practice, efficacy and safety
- Scanning education and credentialing requirements, programs and content
- Reviewing state occupational regulation policies across the U.S.
- Engaging with a wide range of stakeholders, including: Utah and other state governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings

1.2 Dietetics Policy Scan

To better understand the regulatory environment for dietetics, OPLR conducted a review of state occupational regulation in the U.S., which made use Westlaw Advantage's AI Jurisdictional Survey tool and resources from the American Nutrition Association (ANA).

OPLR used Westlaw's AI tool to help determine how jurisdictions regulated dietitians and nutritionists and defined the scope of practice and exemptions from licensure/certification. OPLR analysts then manually validated every state's results by reviewing the linked statutes and administrative rules, and details not included by the AI tool were added during verification.⁶¹ The AI tool was unable to accurately determine the method of regulation, so OPLR corrected all results during this process. The validated sources were then used to map the national policy landscape, find patterns in regulation, make cross-state comparisons, and discover outliers. OPLR also used the data to help inform recommendations.

OPLR used two resources from the ANA, the CNS State-by-State Practice Rights document and a document on MNT laws.⁶² These sources helped inform an initial review of the regulation of nutritionists. OPLR then utilized Westlaw's AI Jurisdictional Survey tool to validate this and find detailed information on the scope of practice and requirements for licensure for nutritionists. OPLR analysts similarly manually validated the policy scan on nutritionists.

⁶¹ This included the requirements for licensure/certification. Despite not being included in the initial prompt, OPLR analysts utilized the linked sources to note requirements for licensure/certification. Specifically, OPLR looked to determine whether a state required the RD exam, as that determines the education and experience requirements more so than the state's actual stated requirements.

⁶² American Nutrition Association, "CNS State-by-State Practice Rights."

The following prompts were used for Westlaw's AI tool:

- What is the scope of practice for dietitians? Who, or what actions, are exempted from the licensure requirement? Note whether the scope is actually protected.
- What is the scope of practice, requirements, and title protection for dietitians and nutritionists?
- What is the scope of practice, requirements, and title protection for dietitians and nutritionists? Provide a detailed explanation of requirements for each license, which are typically found in administrative rules.

The first prompt included all 50 states. The second prompt included only those states that regulated dietitians and nutritionists under the same license, and the third prompt included only those states that regulated dietitians and nutritionists under different licenses. ANA resources helped us determine those distinctions, and the results of the policy scan corrected some incorrect categorizations OPLR initially made.

This review does contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information, errors in data entry, or mistakes made by Westlaw's AI tool that were not caught by OPLR's manual verification. Potential bias or measurement error introduced by these limitations likely did not substantially alter any information, as OPLR engaged in rigorous validation.

2. Regulatory Model Assessment and Recommendations

2.1 Menu of Regulatory Models

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of OPLR's approach to assessing occupational regulation and evaluating different regulatory models.⁶³

2.2 Model Assessment of Dietetics

The following tables summarize OPLR's analysis of dietitians according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered particularly determinative in its assessment are highlighted in bold.

Model Assessment of Dietetics	
Harm Factors	
Mechanism of Harm	Worsening acute or chronic patient conditions, causing malnutrition
Severity, Permanence, and Likelihood of Harm	Typically low to moderate severity and reversible, potential for high severity for highly vulnerable patients (i.e. extremely ill)
Consequence of Error ⁶⁴	34
Downstream Impact	Moderate
Consumer & Setting Factors	
Patient Vulnerability	Variable. Can range from low to high depending on setting and population
Frequency of Physical Touch	Low to moderate
Frequency of Private Setting	Moderate to high; typically meet with patients one-on-one
Information Asymmetry	Moderate

⁶³ The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://commerce.utah.gov/oplr/about/>

⁶⁴ O*Net does not differentiate between dietitians and nutritionists. O*Net rates professions on a 100-point scale based on the seriousness of a consequence of making an error. OPLR has not been able to confirm the legitimacy of their methodology, so while this ranking is a consideration, OPLR does not consider it a deciding factor. National Center for O*NET Development, "Consequence of Error."

Related Factors	
Level of Independence	Structural: Low to moderate. Majority work in supervised or team-based settings, private practice is less common. In private practice, patient/client compliance can be a confounding factor. <i>Clinical: High. Determine nutrition diagnosis and therapeutic interventions</i>
Patient Choice	Variable. High in situations where patient is self-directed/care is voluntary, low in acute settings where care is determined by the facility
Information Availability	Moderate to high. However, the nutrition and diet information marketplace is crowded and likely highly confusing to consumers
Level of Oversight	Employers: Variable; high in acute settings, where patient condition would be most acute, moderate to high in out-patient/long term care settings associated with a healthcare institution, low in private practice Government: Moderate to high. Insurance reimbursement requires proof of competency or state authorization. Outside of insurance provision, the Utah Consumer Sales Practice Act (CSPA) or tort law are the only avenues. <i>Private Bodies:</i> Low to moderate. The CDR and ANA require continuous certification and can discipline certification holders and/or can strip individuals of their certification

2.3 Safety Assessment

OPLR completed the following analysis to evaluate the severity of harm from poor or untrained provision of MNT:

Literature Review

OPLR reviewed academic literature to identify any studies quantifying adverse effects of poor MNT/poor nutrition guidance. While OPLR found extensive information on the benefits of MNT and incorporating nutrition advice into standard care, OPLR could not identify studies detailing harm caused by poorly trained nutritionists, nor any studies comparing the effectiveness of

Registered Dietitians versus nutritionists.⁶⁵ Additionally, OPLR found no studies regarding adverse outcomes of MNT besides that from incorrect administration of enteral feeding in in-patient healthcare facilities.⁶⁶ Few hospitals allow dietitians to administer parenteral feeding, and the case studies did not specify what type of provider was involved in the incident.

To conduct this literature review, OPLR utilized Gemini's deep-research function as well as manual searches on both Google Scholar and the general BYU library database that houses many databases and journals.

Gemini Prompt 1:

Directive: Conduct a systematic literature search for peer-reviewed clinical studies, case reports, epidemiological data, and government health agency reports (e.g., FDA, CDC, NHS, WHO) that document direct, quantifiable physical or psychological harm resulting from the provision of medical nutrition therapy?

Scope & Key Parameters:

Sources of MNT: Focus on the provision of medical nutrition therapy by both dietitians and "unqualified" individuals, such as social media influencers, alternative medicine practitioners, unregulated wellness platforms, fad diet books

Traceable Causality: Evidence must show a direct, traceable causal link between following the dietary advice and the subsequent adverse health outcome. Avoid papers that only discuss "potential risks" or general correlations; prioritize documented clinical cases.

Categories of Documented Harm:

Severe Nutrient Deficiencies: (e.g., neurological damage from extreme veganism without B12 supplementation, scurvy, kwashiorkor/marasmus from restrictive alternative infant diets).

Toxicity and Organ Failure: (e.g., hepatic or renal failure caused by detox diets, heavy metal poisoning from unregulated ayurvedic/herbal supplements, hypervitaminosis).

Delayed/Foregone Medical Treatment: Documentation of patients with treatable chronic conditions (e.g., Type 2 diabetes, cancer) who experienced disease progression or mortality because they substituted standard medical care with nutritional "cures."

Psychological & Behavioral Harm: Clinical onset of eating disorders (e.g., orthorexia nervosa, anorexia) directly triggered by restrictive dietary advice or clean-eating misinformation.

Boolean Search String for Databases: > ("medical nutrition therapy", OR "nutrition counseling", OR "nutrition advice", OR "unregulated supplements", OR "dietitian", OR "nutritionist", OR "alternative medicine") AND ("case report" OR "adverse effects" OR "toxicity" OR "malnutrition" OR "organ failure" OR "mortality" OR "patient harm")

⁶⁵ OPLR found one case study on the impact of malnutrition on a 13-year old boy who was put on a restrictive diet by his parents, but the harm was eventually reversed by treatment from a registered dietitian. This case does not regard medical nutrition therapy, however, as an outside individual did not counsel with the parents to restrict intake. Taheri et al., "Case of Kwashiorkor."

⁶⁶ The following sources are provided as examples: The following sources are provided as examples: Ulicny and Korelitz, "Multiorgan Failure"; Stellato et al., "Inadvertent Intravenous Administration"; Takeshita et al., "Death Resulting from Inadvertent Intravenous Infusion"; Casewell, Cooper, and Webster, "Enteral Feeds Contaminated."

Gemini Prompt 2:

Directive: Conduct a systematic literature search for peer-reviewed clinical studies, case reports, epidemiological data, and government health agency reports (e.g., FDA, CDC, NHS, WHO) that document direct, quantifiable physical or psychological harm resulting from the adoption of scientifically unsubstantiated or "bad" nutrition advice.

Scope & Key Parameters:

Sources of Advice: Focus on non-evidence-based dietary recommendations originating from social media influencers, alternative medicine practitioners, unregulated wellness platforms, fad diet books, or historical public health oversights (e.g., early infant formula mishaps or unregulated dietary supplements).

Traceable Causality: Evidence must show a direct, traceable causal link between following the dietary advice and the subsequent adverse health outcome. Avoid papers that only discuss "potential risks" or general correlations; prioritize documented clinical cases.

Categories of Documented Harm:

Severe Nutrient Deficiencies: (e.g., neurological damage from extreme veganism without B12 supplementation, scurvy, kwashiorkor/marasmus from restrictive alternative infant diets).

Toxicity and Organ Failure: (e.g., hepatic or renal failure caused by detox diets, heavy metal poisoning from unregulated ayurvedic/herbal supplements, hypervitaminosis).

Delayed/Foregone Medical Treatment: Documentation of patients with treatable chronic conditions (e.g., Type 2 diabetes, cancer) who experienced disease progression or mortality because they substituted standard medical care with nutritional "cures."

Psychological & Behavioral Harm: Clinical onset of eating disorders (e.g., orthorexia nervosa, anorexia) directly triggered by restrictive dietary advice or clean-eating misinformation.

Boolean Search String for Databases: > ("nutrition misinformation" OR "dietary advice" OR "fad diets" OR "alternative medicine" OR "unregulated supplements") AND ("case report" OR "adverse effects" OR "toxicity" OR "malnutrition" OR "organ failure" OR "mortality" OR "patient harm")

A selection of terms and phrases for manual searches.⁶⁷

- "Medical nutrition therapy" & "adverse outcomes"
- "Medical nutrition therapy" & "competency"
- "Medical nutrition therapy" & "harm"
- "Medical nutrition therapy" & "untrained"
- "Medical nutrition therapy" & "nutritionist"
- Difference in outcomes of nutritionists and dietitians
- Harm caused by poor MNT
- Harm caused by nutritionists
- Dietitian and nutritionist outcome differences
- "Professional Development Portfolio" AND "Commission on Dietetic Registration" AND "competence"
- "Standards of Practice" AND "Standards of Professional Performance" AND "Registered Dietitian" AND "competency"
- "ACEND" AND "Accreditation Standards" AND "Core Competencies" AND "Dietitian"

⁶⁷ This list is not exhaustive.

Other State Sunrise Reviews

The Institute for Justice reported that five states completed a sunrise review of dietitian licensing, four of which recommended against licensure.⁶⁸ OPLR attempted to verify this and was able to access sunrise reports from Colorado, Washington, Nebraska, and Hawaii.

Washington conducted a sunrise review in 1993 and recommended against moving from certification to licensure, concluding that the potential for actual physical harm is remote.⁶⁹

Nebraska conducted a sunrise review in 1994 and recommended against protecting the scope of MNT specifically.⁷⁰

Hawaii conducted a sunrise review in 1995 and recommended against any regulation of the scope or title, stating that they “found little documented evidence of abuse or harm to the public by nutrition practitioners. Evidence from testimony and interviews was anecdotal.”⁷¹

Colorado has conducted multiple sunrise reviews, one as recently as 2024, and has recommended against licensure in each case. In the 2024 review, they concluded that “in all examples [of harm] provided except one, none of the harm could be attributed to the actions or recommendations of either dietitians or nutritionists...there is insufficient evidence to conclude that an initial assurance of competency...is necessary”.⁷² The examples did illustrate harm caused by other healthcare providers in the provision of MNT or dietary guidance, but in no case did the individual harmed believe they were seeing a dietitian or nutritionist. These anecdotal reports do help substantiate some potential for harm from MNT, but it is important to note that a causal link can not be confirmed in any case and many of the individuals mentioned purposefully sought out alternative health-care providers.

Analyzing Utah Data

OPLR found that, between 2017-2024, only one complaint was made against a practicing dietitian. All others (8) were against unlicensed individuals. OPLR used this information to help inform whether unlicensed nutrition providers are causing present, recognizable harm to the Utah public. OPLR read the complaint notes for each of these complaints and found that only one complaint alleged any harm at all from the untrained provision of nutrition counseling, but DOPL did not verify whether harm actually occurred. In that case, the individual did not claim to be a dietitian, and DOPL determined that the individual was practicing medicine without a license. The other 7 complaints involved the unauthorized use of the title “dietitian”; 2 of which regarded nationally certified RDs without Utah licenses and 3 others that involved one website which didn’t give users the ability to differentiate between dietitian and nutritionist on their

⁶⁸ Sanchez, Smith Pohl, and Knepper, Too Many Licenses?

⁶⁹ Washington State Department of Health, Dietitians and Nutritionists Sunrise Review.

⁷⁰ Nebraska Board of Health, Final Report of Preliminary Findings.

⁷¹ Hawaii State Office of the Auditor, Sunrise Analysis.

⁷² Colorado Office of Policy, Research & Regulatory Reform, Sunrise Review: Medical Nutrition Therapy.

profile. None of these complaints suggested that unlicensed individuals were necessarily providing MNT, much less reporting harm from unqualified individuals.

OPLR also asked the Utah Division of Consumer Protection (DCP) if they received complaints regarding fraudulent dietetics or nutrition counseling. DCP expressed little concern regarding non-dietitians in this space, which may imply this issue is not harmful or widespread enough at this point.

Other States' Data

OPLR contacted a few states that license dietitians and nutritionists to determine whether or not they commonly deal with complaints alleging severe harm.

OPLR spoke with regulators from North Carolina and asked specifically about harm from MNT and the types of complaints regulators receive. Regulators explained that it is difficult to prove harm with nutrition and that they do not receive many regarding physical harm. They expressed some concern regarding financial harm and deceptive advertising in the diet and nutrition field but did not specify how frequent or severe these issues were.

South Dakota responded in an email and explained that their regulatory board receives minimal complaints each year for the profession, but they cannot discuss any details about any complaints, and they do not have jurisdiction over unlicensed practice.

Delaware never responded.

OPLR also reviewed disciplinary actions against dietitians/nutritionists in other states to determine the frequency and severity of complaints. OPLR found publicly available data for Massachusetts, West Virginia, and Illinois. OPLR found no concerning patterns in any of these states given that each state took very few actions against dietitians or unlicensed individuals attempting to practice in the state.^{73,74,75}

⁷³ Massachusetts Division of Occupational Licensure, "Past DOL Disciplinary Actions."

⁷⁴ West Virginia Board of Licensed Dietitians, "Discipline."

⁷⁵ Illinois Governor's Office of Management and Budget, Review of the Dietitian Nutritionist Practice Act.

3. Regulatory Model Adjustments & Recommendations

3.1 Possible Adjustments

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of how OPLR approaches whether adjustments should be made within a recommended regulatory model.⁷⁶

3.2 DOPL Complaint Data

The Division of Professional Licensing (DOPL) receives complaints from individuals, other state agencies, co-workers, professional associations, and licensing boards. DOPL is required to “investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence”.⁷⁷ Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of ways, including: closing an investigation due to a lack of evidence; referring the case to another agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements; issuing a citation; or denying, suspending, or revoking an individual's license.

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) and Salesforce to access closed complaints investigated by DOPL between 2017-2024. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to OPLR's analysis. DOPL personnel helped code the complaint dispositions as either substantiated, unsubstantiated, or no jurisdiction. Substantiated complaints are those where a disposition includes some type of disciplinary action, whether formal or informal (e.g., letter of concern, verbal warning, surrender of license). Unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). ‘No jurisdiction’ complaints are complaints that may or may not have basis, but DOPL was not able to take action on the case.

OPLR filtered complaints to exclude any likely duplicates and then used substantiated complaints to calculate the number of complaints per license type or profession. OPLR estimated the complaint rate for each license type by dividing the number of substantiated complaints by the number of unique individuals who held that license type over the same period.

⁷⁶ The document is also available on OPLR's website in the “About OPLR” section, accessible here: <https://oplr.utah.gov/about-oplr/>

⁷⁷ Utah Division of Occupational and Professional Licensing, Complaint Process.

Complaint Case Notes Analysis

A more detailed analysis of historical case notes was conducted on all dietetics complaints categorized as substantiated or no jurisdiction,⁷⁸ closed between 2017-2024. Of the 9 complaints, 8 were substantiated and 1 was no jurisdiction.⁷⁹ OPLR analysts read through the case notes for each complaint and summarized the issue, noting whether or not client harm occurred or potentially occurred, and if harm was present, noting the type and severity.

Limitations

There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by dietitians. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other entities, or may never be reported. Additionally, some unsubstantiated complaints may have resulted in harm but the necessary evidence was not produced.

There could also be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the comparisons across professions. This is especially true in healthcare, as certain professions, by their nature, include a greater potential for harm and may generate more complaints. For example, surgeons have a higher likelihood of causing severe harm to a patient than dietitians because surgery is inherently far riskier, not because surgeons are “less safe” or less competent than dietitians.

For these reasons, OPLR uses DOPL complaint data as directionally informative, but avoids direct comparisons across professions wherever possible. Fine comparisons across professions are unwarranted and unsupported by these data.

3.3 DOPL Licensee Data

OPLR used DOPL licensee data queried in October of 2025 to conduct analyses on the number of licensees per year.. The dataset included individuals first licensed after 1970 to those actively licensed as of October 2025. Each row in this dataset is a unique combination of individual and license type and contains information regarding when the license was issued, the status of the license, the date the status was last updated, and the sex and year of birth of the individual. OPLR estimated the number of licensees in each year by summing the number of unique individuals whose licenses were active during any point in each year. Additionally, OPLR excluded any individual with a null or incorrect value for their license issue date and license expiration date, as OPLR could not determine how long or for what years they were actively licensed. License counts may slightly underestimate the true number of licensees due to this,

⁷⁸ No jurisdiction complaints were included in the case note analysis and not the complaint rate analysis because they are not complaints where DOPL took an action, but they may include legitimate client harm that DOPL had to refer to another agency. Although they can not be classified as “substantiated”, OPLR felt these complaints could help contextualize client harm resulting from MNT.

⁷⁹ There were technically 10 complaints (9 substantiated), but two regarded the same individual and the same issue, so that incident was treated as one complaint.

but the effect is fairly negligible given OPLR's use of the data to determine trends over time rather than estimate with precision for specific dates.

4. Regulatory Model Adjustments & Recommendations

4.1 Other state approaches to incorporating the CNS⁸⁰

Twenty states accept a broader set of requirements than those set by ACEND for licensure or certification as a dietetics and nutrition provider. Twelve of these states administer separate licenses depending on specific qualifications,⁸¹ while the remaining eight accept multiple pathways to one license/certification.⁸²

Separate License/Certification

- Each state has a separate “dietitian”⁸³ license/certification and “nutritionist” license/certification
- Three states use voluntary certification and nine states use licensure
- In the majority of states with licensure (seven), licensed dietitians and licensed nutritionists share the same scope of practice. The remaining two states restrict the scope of practice for nutritionists to the provision of medical nutrition therapy for noncomplex medical disorders only.⁸⁴
- Requirements for licensure as a nutritionist are fairly similar across all twelve states:⁸⁵
 - Education: All states require a master's or doctoral degree from an accredited institution with a major course of study in a nutrition-related field. Most states specify that an applicant must complete coursework leading to competence in medical nutrition therapy by completing 15 semester hours of clinical or life sciences courses and 15 semester hours of nutrition and metabolism courses.
 - Preprofessional experience: All but two states, Kentucky and Washington, require supervised, preprofessional experience. This experience must be at least 900-1000 hours, with most states requiring 200 hours of nutrition assessment, 200 hours of nutrition intervention/counseling, and 200 hours of nutrition monitoring or evaluation. Some states additionally require that the practice

⁸⁰ OPLR Policy Scan. See Appendix 1.2 for more information on how this was conducted.

⁸¹ These states include: Nebraska, North Carolina, Alaska, Georgia, Kentucky, Minnesota, Montana, New Jersey, New Mexico, North Dakota, Tennessee, and Washington.

⁸² These states include: Connecticut, Delaware, Florida, Illinois, Maryland, Massachusetts, New York, and Pennsylvania.

⁸³ Some states call them “dietitian-nutritionists”.

⁸⁴ Both states, Georgia and Tennessee, define this similarly. Georgia defines a noncomplex medical condition as “a disease state, medical condition, or clinical presentation that is stable, does not involve rapid clinical deterioration or high acuity care needs, and can be safely addressed through medical nutrition therapy delivered in low acuity outpatient settings by a practitioner practicing within their demonstrated level of competence. Noncomplex conditions do not require intensive monitoring, do not involve multiple interacting high acuity comorbidities, and do not necessitate advanced interventions such as therapeutic diets delivered via enteral or parenteral nutrition”.

⁸⁵ OPLR excluded New Mexico from the analysis of requirements for licensure as the statute and rule conflicted.

experience include providing nutrition care to diverse populations and for a range of complex and non-complex medical conditions

- Examination:
 - Four states do not mention an examination requirement
 - All others require the CNS exam; three of which also accept the Diplomate of the American Clinical Board of Nutrition (DACBN) exam⁸⁶
- A few states additionally require active certification as a CNS or equivalent certification
- Alaska and Minnesota accept CNS certification in lieu of education, experience, and testing requirements.

Combined license/certification

- Each state has only one license/certification for nutrition providers referred to as “dietitian-nutritionists” in the practice act, with at least six states specifically protecting some version of that term
- Four states use voluntary certification and four states use licensure
- All states, except Pennsylvania,⁸⁷ additionally protect some version of the titles “dietitian” and “nutritionist”, enabling anyone certified or licensed under their respective acts to use either term
- Requirements for certification vary slightly across these states:
 - Education: All states, except New York,⁸⁸ require a bachelor’s or master’s degree from an accredited program or institution with a major course of study in a nutrition or dietetics related field. Five states require the program to meet certain accreditation standards and/or include a number of semester hours in specific topics
 - Preprofessional Experience: All states require completion of supervised practice in dietetics/nutrition of 900-1000 hours. Some specify the requirements a supervisor must meet and the number of hours of experience required in specific areas. Connecticut doesn’t explicitly require this, but they require an applicant to pass either the RD or CNS exams, which require experience to sit for.
 - Exam: All states require passing the RD or CNS exams.⁸⁹ One state, Illinois, accepts the following private certifications for licensure as a dietitian-nutritionist:

⁸⁶ The American Clinical Board of Nutrition is the certifying agency for the DACBN certification, which “is an advanced-level professional who practices clinical nutrition as a model of preventative health care in their respective health care setting and role”. Eligibility requires a doctorate in a health profession (e.g., MD, DO, DC, ND), 300 clock hours of specialized training in nutrition, proof of publication or proof of acceptance for publication of a clinical nutrition article in a Board approved peer reviewed journal, one year of experience in the practice of nutrition, and passing the DACBN exam. The exam contains 150 multiple-choice questions. American Clinical Board of Nutrition, 2023 Candidate Handbook.

⁸⁷ Pennsylvania only explicitly protects the title “licensed dietitian-nutritionist”; it’s unclear whether they would consider using the title “licensed dietitian” or “licensed nutritionist” violations of the practice act.

⁸⁸ New York accepts an associate’s degree if an applicant has 10 full-time equivalent years of education or work experience in nutrition and dietetics.

⁸⁹ New York and Massachusetts may accept other exams as well, but OPLR could not confirm this.

RD, CNS, DACBN, and certified clinical nutritionist (CCN),⁹⁰ and therefore accepts the exams associated with those certifications

- At least one state (Maryland) requires certification as an RD or CNS

An applicant with a CNS may not be eligible for licensure or certification in certain states because some states have stricter education and experience requirements than the ANA. For example, the ANA accepts a wide range of degrees (i.e. nursing, biochemistry, public health) for a CNS certification, which certain states may not accept. This differentiates the CNS from RD, as CDR's requirements for an RD certification are more aligned with state certification/licensure requirements.

5. Stakeholder Outreach

5.1 OPLR Stakeholder Series

OPLR relied heavily on stakeholder engagement and qualitative interview data, combined with OPLR's other analysis, to conduct this review and develop recommendations. OPLR engaged with practitioners (RDs and CNS), industry associations, employers, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders.

Interviews were conducted via video conferencing using semi-structured interview methods; they were conducted one-on-one and with multiple members. Extensive notes were taken for all interviews.

OPLR conducted initial interviews to understand the dietetics and nutrition industry, determine potential issues related to safety and access, and identify potential areas for change. OPLR engaged with stakeholders later in its review to test initial findings from analysis and preliminary recommendations.

Limitations

This interview sample was not randomly selected and, therefore, is not completely representative. OPLR spoke to individuals most likely to represent the broad aims and concerns of their groups. Additionally, OPLR did not contact consumers of dietetic and nutrition services, so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood to be fully representative of the views of all Utahns, RDs, CNS, or any other person, group, or population.

⁹⁰ The Clinical Nutrition Certification Board is the certifying body for the CCN. A CCN requires one of the following: 1) a bachelor's of science and completion of the Post Graduate Studies in Clinical Nutrition (PGSCN) online program, 2) an advanced professional degree in a licensed health-care field plus 56 hours of online training within the PGSCN program, 3) a Masters, Ph.D, or D.Sc. in Human Nutrition, as well as completion of the CCN exam. Clinical Nutrition Certification Board, "Steps to Credentialing."

Note that stakeholders' views are not always reflected in OPLR's recommendations. OPLR is directed by Utah Code 13-1b-302 to apply specific review criteria. These can and do lead to recommendations that diverge from stakeholder preferences. A stakeholder's appearance here is not an endorsement of OPLR's recommendations as such.

5.2 Stakeholder Engagement Summary

Stakeholder Engagement Summary	
Government Stakeholders	
Utah Department of Commerce	Deborah Blackburn , Assistant Division Director, Division of Professional Licensing David Wright , Bureau Manager, DOPL Mark Steinagel , Deputy Commissioner, Department of Commerce & Director, Division of Professional Licensing
Utah Division of Consumer Protection	Glen Minson , Chief Investigator
Other State Governmental Agencies	Henry Jones , General Counsel, North Carolina Board of Dietetics/Nutrition Marnie Jones , Executive Director, North Carolina Board of Dietetics/Nutrition
Industry Stakeholders	
Industry Associations	Jeremiah McGuire , President, Utah Academy of Nutrition and Dietetics; Faculty, University of Utah Amy Smith , Senior Director of Nutrition Programs and Advocacy, American Nutrition Association Keshele Stevens , Public Policy Coordinator, Utah Academy of Nutrition and Dietetics; Clinical Dietitian, Intermountain Health Care
Subject-Matter Experts	
Academics, Researchers, & Clinicians	Sarah Bellini , Professor, Brigham Young University Melanee Dahl , Clinical Nutritionist & Owner, Integrative Function Nutrition Eric Hazzard , Sr. Director of Business Development, NourishedRx Rebecca Hurst Davis , Clinical Nutrition Director of Pediatrics, Intermountain Health Care Joy Musselman , Senior Director for Clinical Nutrition, Intermountain Health Care Lacie Peterson , Clinical Professor & Director of the Master of Dietetics Administration, Utah State University Paige Smathers , Dietitian & Owner, Positive Nutrition Casey Slater , Utah Healthcare Education Collaboration Program Manager, Talent Ready Utah Kelly Tsougas , Director of Clinical Operations & Registered Dietitian, NourishedRx

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