STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

POST-DOCTORAL HOMEOPATHIC TRAINING VERIFICATION FORM

Applicant: Enter your full name and birth date on this form and forward it to the Program Administrator for completion. This form must be completed by the program administrator and returned directly to this office.

Applicant's Name _____ Date of Birth _____

Chief of Staff/Program Director: Please provide the following verification of post-doctoral training for the above-named Connecticut physician**.**

Name and location of facility/institution where post-doctoral training was completed:

_____

Dates of training: from _____ / _____ / _____ To: _____ / _____ / _____

Did the applicant complete 120 hours of post-doctoral medical training in homeopathy? _____

At the time of the applicant's training, was the training program approved by American Institute of Homeopathy? YES ☐ NO ☐.

At the time of the applicant's training, was the training program approved by the Connecticut Homeopathic Medical Examining Board? YES ☐ NO ☐.

Did the applicant satisfactorily complete this period of post-doctoral training? YES ☐ NO ☐.

Do you have **any derogatory** information **regarding** the competency or conduct of **this applicant**? YES ☐ NO ☐ If Yes, please attach any disclosable documents you may have on file regarding such information.

I, _____, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: _____

Address: _____

_____

Telephone Number: _____

and that the information provided herein is true and correct to the best of my knowledge and belief.

_____
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this _____ day of _____ (month/ year)_____

_____ _____
Notary Public's Signature My Commission Expires

Please complete and return directly to:

Department of Public Health
Homeopathic Physician Licensure
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308