STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

MASSAGE THERAPY VERIFICATION OF LICENSURE

TO BE COMPLETED BY APPLICANT

Applicant - Complete the top portion of this form and forward it to each state where you have been licensed, certified or registered as a massage therapist (make copies as necessary).

Name: _____
Last *First* *Middle* *Maiden*

Address: _____
No. & Street *City* *State* *Zip Code*

Original License number _____ Date Issued _____
(in the state to which the form is being forwarded)

I hereby authorize the _____ to furnish the Connecticut Department of Public Health the information requested below.

Signature _____ **Date** _____

TO BE COMPLETED BY LICENSING AGENCY ONLY

This is to certify that the above named individual was issued license number _____ to practice as a massage therapist effective _____

Basis for licensure in your state: Endorsement ☐ Examination ☐

Current Status: Active ☐ Inactive ☐ Lapsed ☐

Date license expires: _____

Has this individual ever been subjected to disciplinary action of any type or is this individual currently the subject of a pending disciplinary action or unresolved complaint? **YES** ☐ **NO** ☐. If yes, please forward all publicly disclosable information regarding the individual's status and the basis for same.

SEAL Signed: _____ Title: _____

State: _____ Date: _____

Telephone Number: _____

PLEASE COMPLETE AND RETURN DIRECTLY TO:

DEPARTMENT OF PUBLIC HEALTH
MASSAGE THERAPIST LICENSURE
410 CAPITOL AVE., **MS# 12APP**
P.O. BOX 340308
HARTFORD, CT 06134-0308
(860) 509-7603