STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF MARITAL AND FAMILY THERAPY 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 marital and family 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 marital and family therapy 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: _____

Email: _____

PLEASE RETURN DIRECTLY TO:

Department of Public Health
Marital and Family Therapy Licensure
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7603