STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NURSE MIDWIFE LICENSURE VERIFICATION

TO BE COMPLETED BY APPLICANT

Applicant- Complete the top portion of this form and forward it to each state where you have been licensed as a registered or nurse midwife (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 state of _____ 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 registered or nurse midwife effective _____.

What examination did this applicant complete for purposes of licensure? ☐ NCLEX, ☐ SBTPE. If SBTPE, please indicate score _____.

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. Please advise this office if you require a consent for release of this information from the applicant.

SEAL

Signed: _____ Title _____

State: _____ Date _____

Telephone Number: _____

Please return to:

Department of Public Health
Nurse-Midwife Licensure
410 Capitol Avenue MS# **12APP**
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7603