STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Perfusionist
VERIFICATION OF PERFUSION CASES

TO BE COMPLETED BY APPLICANT

Applicant: Please complete the top portion of this form **and forward it** to the institution(s) where you completed perfusion cases.

NAME: _____
First Middle Last Maiden

DATE OF BIRTH: _____/_____/_____

TO BE COMPLETED BY FACILITY ONLY

The above individual is applying for a Connecticut perfusionist license. Please provide the following information:

I certify that the above named applicant was employed as a perfusionist at this facility from _____ to _____ as a Perfusionist and during that time, this applicant performed **AT LEAST FIFTY (50)** perfusion cases. If the applicant did

not complete at least 50 perfusion cases, please indicate the number of case completed: _____

Was this period of employment satisfactorily completed? **YES** ☐ **NO** ☐. If NO, please attach any documents you may have on file regarding such information

_____ _____ _____
Name and Title ***Signature*** ***Date***

_____
Name of Facility

_____
Full Address of Facility

_____ _____
Daytime telephone number ***Email***

Your prompt attention to this matter is appreciated, as this application cannot be processed until this information is received.

Please return this form **directly** to:

Department of Public Health
Perfusionist Licensure
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1982