STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF LICENSURE

APPLICANT: Complete the top portion of this form and forward it to each state where you have been licensed as a physician (make copies as necessary). **The Medical Examining Board should complete and return the entire form to this office.**

Name: _____
Last First MI 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** _____

DO NOT WRITE BELOW THIS LINE--FOR LICENSING AGENCY USE ONLY

This is to certify that the above named individual was issued license number_____ to practice as a physician effective _____.

Basis for licensure in your state: **Endorsement** ☐ **Examination** ☐
If a State Board Examination was given, please attach a listing of the subject areas and the scores received.

Current Status: **Active** ☐ **Inactive** ☐ **Expired** ☐

Date license expires: _____

Has this individual ever been subject 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.

Signed: _____ **Title** _____

State: _____ **Date** _____

Telephone Number: _____

Email: _____

Please return this form directly to:

Connecticut Department of Public Health
Physician Licensure
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1931