STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
ENDO ☐ REINST ☐ EXAM ☐

PRACTICAL NURSE WORK EXPERIENCE VERIFICATION

TO BE COMPLETED BY APPLICANT

Applicant should complete the top portion of this form and forward to the most recent employer(s) for completion.

Name of Applicant: _____

Dates of Employment: FROM: _____ TO: _____

TO BE COMPLETED BY EMPLOYER ONLY

The above individual is applying for nurse licensure in Connecticut. Please provide the following information:

This is to certify that _____ (name of applicant) was employed at our facility from _____ to _____ as a practical nurse.

Number of hours worked per week: _____

Please check the area(s) in which the applicant has obtained work experience within your facility:

☐ medical/surgical nursing ☐ geriatric nursing ☐ maternal/child health nursing

☐ other (please explain): _____

_____

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

_____
Name of Facility

_____
Full Address of Facility

_____
Daytime telephone number

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
LPN Licensure
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7603
www.dph.state.ct.us