STATE OF CONNECTICUT-DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN ASSISTANT LICENSURE

VERIFICATION OF LICENSURE/CERTIFICATION/REGISTRATION

Applicant- Complete the top portion of this form and forward it to each state where you have been licensed, certified or registered as a physician assistant (make copies as necessary).

NAME:_____
Last **First** **Middle** **Maiden**

ADDRESS_____
No. & Street **City** **State** **Zip Code**

Original license, certification or registration 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, certification or registration number _____to practice as a physician assistant effective _____.

Current Status: Active ☐
Inactive ☐
Expired ☐

Date license, certification or registration 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 consent for release of this information from the applicant.

SEAL Signed: _____ Title _____

State: _____ Date _____

Telephone Number: _____

Please complete and return directly to:

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