STATE OF CONNECTICUT

RADIOGRAPHER LICENSE 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 Radiographer (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 _____ 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 Radiographer effective _____.

Basis for licensure in your state: Endorsement ☐ Examination ☐

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 discloseable information regarding the individual's status and the basis for same.

SEAL

Signed: _____ Title: _____

State: _____ Date: _____

Day Time Telephone Number: _____

Email: _____

Please complete and return directly to:

Department of Public Health
Radiographer Licensure
410 Capitol Avenue MS# **12APP**
P.O. Box 340308 Hartford, CT 06134-0308