



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

RESPIRATORY CARE PRACTITIONER

VERIFICATION OF LICENSURE/CERTIFICATION/REGISTRATION

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 respiratory care practitioner (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 respiratory care practitioner 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.

Signed: _____ Title: _____

State: _____ Date: _____

Day Time Telephone Number: _____

Please complete and return directly to:

Department of Public Health
Respiratory Care Practitioner Licensure
410 Capitol Avenue MS# 12APP
P.O. Box 340308 Hartford, CT 06134-0308
(860) 509-7603