STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
SPEECH AND LANGUAGE PATHOLOGY / AUDIOLOGY 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 speech and language pathologist (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 speech and language pathologist effective _____.

Current Status: Active _____
Inactive _____
Lapsed _____

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 a 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
SPEECH AND LANGUAGE PATHOLOGY/AUDIOLOGY LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308