STATE OF CONNECTICUT-DEPARTMENT OF PUBLIC HEALTH
PHYSICAL THERAPIST 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 physical therapist (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 USE ONLY

This is to certify that the above named individual was issued license, certification or registration number _____ to practice physical therapy 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
Physical Therapy Licensure
410 Capitol Ave., MS#12APP
P.O. Box 340308
Hartford, CT 06134