STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Please check the appropriate box

☐ **REQUEST RENEWAL APPLICATION** ☐ **NAME CHANGE**

☐ **REQUEST DUPLICATE LICENSE** ☐ **ADDRESS CHANGE**

All requests should be mailed or faxed to the attention of your profession to:

Connecticut Department of Public Health
PLIS
410 Capitol Ave., MS # 12 APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 509-8457
Email: oplc.dph@ct.gov

Print/Type clearly the information requested:

License Number: ________________ Profession: ______________________ SSN: _________________

Information as it is **NOW SHOWN** on your license:	Print /Type the information as you wish it to appear on your new license:
Last Name:____________________________________	Last Name:____________________________________
First Name:______________________ MI: _______	First Name:________________________ MI: ______
Street Address 1:________________________________	Street Address 1:_______________________________
Street Address 2:________________________________	Street Address 2:_______________________________
Apt/Suite:______________________________________	Apt/Suite:_____________________________________
City: _____________________ State: ___________	City: _______________________ State: __________
Postal Code:______________________________	Postal Code:_____________________________
Country: ________________________________	Country: _______________________________

I declare that the information provided herein is a truthful and complete statement of the information requested.

Signature: ____

Email Address: ____

Date: ____