STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

NATUROPATHIC LICENSE VERIFICATION

Applicant - Complete the top portion of this form and forward it to each state where you have been licensed as a naturopathic physician (make copies as necessary).

Name:	Last	First	Middle	Maiden
4 1 1				Maiuch
	No. & Street	City	State	Zip Code
-	ense number to which the form is be		_ Date Issued	
	horize the ealth the information rec		to furnish the Cor	nnecticut Department
Signature _			Date	
	TO BE CO	OMPLETED BY L	ICENSING AGENCY ONLY	
	rtify that the above nam		sued license number	to practice as
Basis for lic	ensure in your state:	Endorsement	Examination	
Current Stat	us: Active	Inactive	Lapsed	
Date license	expires:			
subject of a	pending disciplinary act	tion or unresolved co	ction of any type or is this individ omplaint? YES NO . . If ye I's status and the basis for same.	
	Signed:		Title:	
	State:		_ Date:	
	Day Time Telephone	Number:		
		Please complete an	d return directly to:	
		Department of Naturopathic Ph 410 Capitol Ave P.O. Boy	Public Health ysician Licensure nue MS# 12APP x 340308 06134-0308	