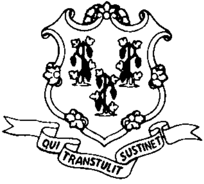

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CLINICAL SOCIAL WORK LICENSURE
VERIFICATION OF LICENSURE/CERTIFICATION

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

Name: ____

Last **First** **Middle** **Maiden**

Address: ____

No. & Street **City** **State** **Zip Code**

Original License or Certification ___________________ 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 or certification number ____________________________ to practice as a social worker effective __________________________________.

Current Status: Active ☐
Inactive ☐
Lapsed ☐

Date license, certification or registration expires: ____

What was the basis for licensure/certification in your state? Endorsement ☐ Examination ☐

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 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
CLINICAL SOCIAL WORK LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308