



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

HOMEOPATHIC PHYSICIAN APPLICATION

Please check one: Initial licensure Reinstatement CT License No. _____ Date Granted: _____

PLEASE INDICATE (X) THE EXAMINATION(S) YOU COMPLETED:

<input type="checkbox"/> National Board of Medical Examiners (NBME)	<input type="checkbox"/> Federation Licensing Examination (FLEX)
<input type="checkbox"/> State Board Licensing Exam _____ (State) Year Taken: _____	<input type="checkbox"/> Licentiate of the Medical Council of Canada (LMCC)
<input type="checkbox"/> United States Medical Licensing Examination (USMLE)	<input type="checkbox"/> Combination of Segments (please specify)

Last Name: _____ MI: _____ First Name: _____ Maiden Name: _____

Social Security No.: _____ - _____ - _____ E-mail: _____

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: _____

Address: _____

City, State, Zip: _____

Phone Number: (_____) _____ Date of Birth: ____/____/____ Gender: _____

RACE/ETHNIC DATA: (This section is voluntary. Information gathered will be used solely for the purpose of examining the demographics of Connecticut licensees. This data will not be used for discriminatory purposes and will not be considered in the evaluation of your application.)

- AMERICAN INDIAN OR ALASKAN NATIVE: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- ASIAN OR PACIFIC ISLANDER: Persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent of the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.
- BLACK: Persons having origins in any of the black racial groups of Africa.
- HISPANIC: Persons of Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
- WHITE (not of Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

MEDICAL EDUCATION:

List name and location of medical school(s) attended _____ Dates of Attendance _____

M.D. DEGREE AWARDED BY: _____ **DATE AWARDED:** _____
(Name of Medical School)

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. Yes No
If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? Yes No
If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? Yes No
If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.
8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency? Yes No
If your answer is "yes", give full details, dates, etc., on a separate notarized statement.

On this _____ day of _____ (month/ year) _____ (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

Affix a recent photograph here.

DO NOT STAPLE

All of the above statements contained herein are true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT

Sworn to me this _____ day of _____ (month/year) _____.

Notary Public Signature _____ My Commission Expires _____.

Please return this application, the fee for \$565.00 (certified bank check or money order) and a separate certified bank check or money order for \$4.75 made payable to, "Treasurer, State of Connecticut" to:

Department of Public Health
 Homeopathic Physician Licensure
 410 Capitol Ave., MS# 12MQA
 P.O. Box 340308
 Hartford, CT 06134-0308

IMPORTANT: Please do not send this form and fee unless you have read and understood the licensing policies and requirements. All fees are nonrefundable.