



STATE OF CONNECTICUT

RADIOGRAPHER LICENSURE VERIFICATION OF COURSE OF STUDY

TO BE COMPLETED BY APPLICANT

Please complete the top portion of this form and forward to the educational institution for official verification of completion of a course of study in radiologic technology.

Name: _____

Name of School: _____

Enrolled From: _____ To: _____

Identification information required by verifying entity (e.g., certification number): _____

TO BE COMPLETED BY EDUCATIONAL INSTITUTION ONLY

The applicant listed above is applying for radiographer licensure in Connecticut. Please provide the following information regarding the course of study that such individual completed.

Did this individual satisfactorily complete a course of study in radiologic technology in a program which, at the time of this individual's graduation, was accredited by the Joint Review Committee on Education and Radiologic Technology? Yes No .

Where was such instruction completed? _____

Dates of candidate's attendance: From _____/_____/_____ To _____/_____/_____

Did this individual complete your program in good standing? Yes No

If not, please explain: _____

Thank you for your prompt attention to this matter.

Signature and Title: _____ Date: _____

Daytime telephone number: _____

Email: _____

Please return this form directly to:

Department of Public Health
Radiographer Licensure
410 Capitol Avenue
MS# 12APP P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7603