# STATE OF CONNECTICUT

**DEPARTMENT OF PUBLIC HEALTH**

**VERIFICATION OF LICENSED WORK EXPERIENCE**
**AS A CHIROPRACTOR**

**INSTRUCTIONS:**

This form is to be used for verification of licensed work experience only if you meet all applicable requirements for Connecticut licensure by waiver of examination based on licensed practice. Please complete the upper portion of the form and forward the form to the individual who will be verifying your experience. The individual providing the verification must complete the lower portion and return this form directly to this office.

***TO BE COMPLETED BY APPLICANT***

Name of Applicant: _____ Date of Birth: _____ / _____ / _____

***TO BE COMPLETED BY PERSON PROVIDING VERIFICATION***

Name of individual verifying applicant's experience: _____

Licenses held by individual verifying experience, if any (give state and license #): _____

Position held in clinical or academic setting: _____

Source of knowledge regarding applicant's experience: _____

Site of applicant's experience: _____
Name of Institution

Address: _____
No. & Street City State Zip Code

Inclusive dates of applicant's experience: From _____ To _____

Responsibilities carried out by applicant: _____

_____

I understand in completing this verification that I may be asked to provide further documentation; I agree to provide written records upon the request of the Department of Public Health to substantiate this verification of applicant's experience.

Signed: _____ Title _____

Date _____ Daytime Telephone Number: _____

Email: _____

Please complete and return directly to:

Department of Public Health
Chiropractic Licensure
410 Capitol Avenue MS# **12APP**
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1982