STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Connecticut Nurse's Aide Employment Verification Form

Agency Name: _____CT License No. _____

Address: _____

City: _____ State: _____ Zip code: _____

Completed by:_____ Title: _____

Telephone No.:_____ Email:_____

Date Completed: _____

The following individuals have been employed by this facility as nurse's aides during the previous 24 months:

NA Reg. No.	SSN	Last Name	First Name	Hire Date	Last Date Worked

** It is the nurse's aide responsibility to notify the registry of any changes to their contact information or mailing address.*

Please note: this form must be completed in its entirety and mailed or faxed directly from the employer to:

CT Nurse Aide Registry Program
Department of Public Health
410 Capitol Avenue, MS#12MQA
P.O. Box 340308
Hartford, CT 06134-0308
Facsimile: (860) 707-1983

Revised: 4/14/14