STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OCCUPATIONAL THERAPY

VERIFICATION OF LICENSURE/CERTIFICATION/REGISTRATION

TO BE COMPLETED BY APPLICANT

APPLICANT: Complete the top portion of this form and forward it to each state where you are now or have ever been licensed, certified or registered as an occupational therapist (make copies as necessary).

Name: _____
Last First Middle Maiden

Address: _____
No. & Street City State Zip Code

Original License _____ Date Issued _____ In (State) _____

I hereby authorize the _____ to furnish the Connecticut Department of Public Health the information requested below.

Signature _____ Date _____

TO BE COMPLETED BY LICENSING AGENCY ONLY

This is to certify that the above named individual was issued license/certification/registration number _____ in the state of _____ to practice as an

Occupational Therapist ☐ / Occupational Therapy Assistant ☐ effective _____.

Current Status: Active ☐ Inactive ☐ Lapsed ☐

Date license, certification or registration expires: _____

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.

Name/Title _____ Telephone _____

Signature _____

State/Agency _____ Date _____

PLEASE COMPLETE AND RETURN DIRECTLY TO:

Department of Public Health
OT/OTA Licensure
410 Capitol Ave., MS **#12APP**
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7603