



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH Perfusionist Licensure

### 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 have been licensed as a perfusionist (make copies as necessary).*

Name: \_\_\_\_\_  
Last First Middle Maiden

Address: \_\_\_\_\_  
No. & Street City State Zip Code

Original License number \_\_\_\_\_ Date Issued \_\_\_\_\_  
(in the state to which the form is being forwarded)

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 number \_\_\_\_\_ to practice as a perfusionist effective \_\_\_\_\_.

Basis for licensure in your state: Endorsement  Examination

Current Status: Active  Inactive  Lapsed  Date license expires: \_\_\_\_\_

### Important

**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 discloseable information regarding the individual's status and the basis for same.**

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

State: \_\_\_\_\_ Date: \_\_\_\_\_

Day Time Telephone Number: \_\_\_\_\_

Please complete and return directly to: Department of Public Health:

Perfusionist Licensure  
410 Capitol Avenue MS# 12APP  
P.O. Box 340308  
Hartford, CT 06134-0308  
Fax: (860) 707-1982