



**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

PROFESSIONAL COUNSELOR

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 a professional counselor (make copies as necessary).

Name: _____
Last First Middle Maiden

Address: _____
No. & Street City State Zip Code

Original License or Certification _____ 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 a professional counselor effective _____.

Current Status: Active Inactive Lapsed

Date license, certification or registration expires: _____

What was the basis for licensure/certification/registration in your state? Endorsement Examination

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: _____

State/Agency: _____ Date: _____/_____/_____

Signed _____ Email: _____

PLEASE COMPLETE AND RETURN DIRECTLY TO:

DEPARTMENT OF PUBLIC HEALTH
PROFESSIONAL COUNSELOR LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308
Fax: (860) 707-1980