STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

RESPIRATORY CARE PRACTITIONER
VERIFICATION OF EDUCATIONAL PROGRAM

TO BE COMPLETED BY APPLICANT

Applicant: Please complete the top portion of this form and forward to the educational institution where you completed a respiratory therapy or respiratory therapy technicians program.

NAME: _____
First Middle Last Maiden

Identification information (i.e. Social security number) if required by verifying entity _____

DATE OF BIRTH: _____/_____/_____ **YEAR OF COMPLETION** _____

TO BE COMPLETED BY EDUCATIONAL INSTITUTION ONLY

The applicant listed above is applying for respiratory care practitioner licensure in Connecticut. Please provide the following information regarding the course of study that such individual completed.

Did this individual satisfactorily complete an educational program for respiratory therapists or respiratory therapy technicians which, at the time of completion, was accredited by the Committee on Allied Health Education and Accreditation, or the Commission on Allied Health Education Programs, in cooperation with the Joint Review Committee for Respiratory Therapy Education (JRCRTE), or was recognized by JRCRTE or the Committee on Accreditation for Respiratory Care (COARC)? **YES** ☐ **NO** ☐

Please Check One: ☐ Respiratory Therapist ☐ Respiratory Therapy Technician

Where was such instruction completed?_____

_____

Dates of candidate's attendance: From: _____ To: _____

_____ _____
Signature of authorized representative Date

_____ _____
Title Institution

Daytime telephone number.:_____

Thank you for your assistance. Please return this form **directly** to:

DEPARTMENT OF PUBLIC HEALTH
RESPIRATORY CARE PRACTITIONER LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308