STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
ADVANCED PRACTICE REGISTERED NURSE LICENSURE VERIFICATION

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 nurse (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 state of _____ 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 nurse effective _____.

What examination did this applicant complete for purposes of licensure? ☐ NCLEX, ☐ SBTPE. If SBTPE, please indicate score _____.

Current Status:
Active ☐
Inactive ☐
Lapsed ☐
Expiration Date: _____

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. Please advise this office if you require consent for release of this information from the applicant.

Signed: _____ Title _____

State: _____ Date _____

Time Telephone Number: _____

Please return this form directly to:
Department of Public Health
APRN Licensure
410 Capitol Avenue MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 509-8457