

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

Veterinarian Licensing

Email: dph.healingarts@ct.gov

www.ct.gov/dph/license

**Tape a recent photo
of applicant here.
DO NOT STAPLE**

Veterinarian Application

This application must be accompanied by a check or money order in the amount of **\$565.00**, payable to **"Treasurer, State of Connecticut."**

➔ **Return completed application and fee to:**

CT DPH, Veterinarian Licensing Application Processing, 410 Capitol Ave., MS# 12MQA, PO Box 340308, Hartford, CT 06134

First Name		MI	Last Name		Maiden Name	Social Security Number	
Email Address			Street Address		City	State	Postal Code
Telephone Number		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		Ethnicity: check (✓) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
Race: Please check (✓) all that apply <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White							
Have you held a Connecticut veterinarian license in the past?						<input type="checkbox"/> Yes <input type="checkbox"/> No	Lic. No.
Are you now or have you ever been licensed as a veterinarian in any state? If yes, please list all (please abbreviate): _____							
Veterinary Educational Program Name			City		State	Degree Date	
Have you taken and passed the National Board Examination (NBME) and the Clinical Competency Test (CCT) or the North American Licensing Examination (NAVLE)?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan to sit for NAVLE as a Connecticut candidate?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Please check (✓) one <input type="checkbox"/> April <input type="checkbox"/> November/December		
If you plan to take the NAVLE as a Connecticut candidate, will you require accommodation for any disability? If yes, attach a statement describing the nature of the disability and the requested accommodation.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: Any hospital, nursing home, clinic, or similar institution; Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public; Any professional school, clinical clerkship, internship, externship, preceptorship; or postgraduate training program; Any third party reimbursement program, whether governmental or private?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever entered into, or do you currently have pending, a consent agreement, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered yes to any of the above questions regarding your professional history, please provide full details and provide supporting documentation (e.g. certified court copy with court seal affixed, complaint, answer, judgment, settlement or disposition) that will assist this office's review.							
NOTARIZATION: On this _____ day of _____ 20____, the above referenced individual personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein or any document attached hereto are true in every respect.							
Sworn to before me this ____ day of _____ 20_____.							
_____ Signature of Applicant				_____ Signature of Notary Public		My Commission Expires: _____	