

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
HAIRDRESSER/BARBER LICENSE APPLICATION**

<u>OFFICE USE ONLY</u>	
License #	_____
Issue Date	_____
Exp. Date	_____

CHECK ONE: HAIRDRESSER LICENSE Fee **\$100.00**

REINSTATEMENT? YES NO **IF YES, LICENSE #** _____

First Name: _____ MI: _____ Last Name: _____ Maiden Name: _____

Social Security No.: _____ - _____ - _____ E-mail: _____

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: _____

Address: _____

City, State, Zip: _____

Phone Number: (_____) _____ Date of Birth: ____/____/____ Gender: _____
Month Day Year

EDUCATION: Have you successfully completed the eighth grade or its equivalent? YES NO

HAIRDRESSER/BARBER SCHOOL(S): *List name, location and exact dates of attendance for all schools ever attended.*

EXAM: Have you ever taken and passed a hairdressing/cosmetology or barbering licensing examination?

YES NO *If Yes, Date of test: ____/____/____ State: _____ Language given in: _____*

If you plan to take the Connecticut exam, will you require accommodation for any disability? YES NO

****If YES, attach a written statement to this application briefly describing the nature of the disability and the accommodation you are seeking. Upon review of your request, this office will contact you for appropriate documentation.**

LICENSURE:

Are you now, or have you ever been, licensed as a hairdresser or barber in any state? YES NO

If yes, please list all, attach a separate sheet if necessary: _____

STATEMENT OF PROFESSIONAL HISTORY:

Answer 1-7 by checking YES or NO. If you answer yes to any of the questions, please refer to the instructions below.

1. 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;

YES NO

-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?

If YES, give full details, names, addresses, etc. on a separate, NOTARIZED statement.

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?

YES NO

If YES, give name of professional society or association, date, and reasons your membership was suspended or revoked on a separate, NOTARIZED statement.

3. 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?

YES NO

4. 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?

YES NO

5. 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? You need not report any complaints dismissed as without merit?

YES NO

If you answered YES to any of the above questions (3-5), give full details, names, addresses, etc. on a separate, NOTARIZED statement.

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, 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?

YES NO

If YES, give full details on a separate NOTARIZED statement and submit a NOTARIZED copy of the agreement

7. Have you ever 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?

YES NO

If YES, give full details on a separate, NOTARIZED statement and furnish a CERTIFIED COURT COPY (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.

EMPLOYMENT:

List, starting with your most recent position, your hairdressing/barbering employment experiences. Attach additional sheets if necessary. Do NOT leave this section blank, if you have no experience, indicate N/A.

EMPLOYER & ADDRESS
[]

YOUR SUPERVISOR
[]
YOUR TITLE
[]

EMPLOYMENT DATES
[] TO []

EMPLOYER & ADDRESS
[]

YOUR SUPERVISOR
[]
YOUR TITLE
[]

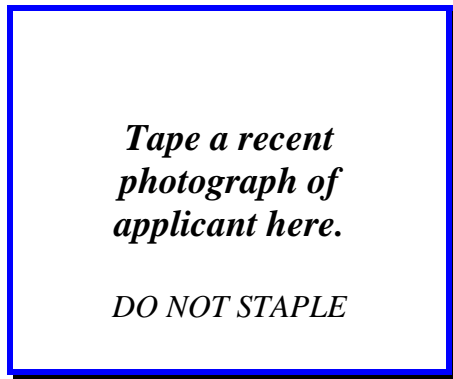
EMPLOYMENT DATES
[] TO []

EMPLOYER & ADDRESS
[]

YOUR SUPERVISOR
[]
YOUR TITLE
[]

EMPLOYMENT DATES
[] TO []

PHOTOGRAPH:



NOTARIZATION:

On this _____ day of _____, 20 _____,

(applicant's name)
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 are true in every respect.
Sworn to before me this _____ day of _____, 20 _____.

SIGNATURE OF APPLICANT

Signature Of Notary Public _____ My commission expires _____

Please return this application and fee for \$100.00, in the form of a certified bank check or money order made payable to, "Treasurer, State of Connecticut" to:

Department of Public Health
Hairdresser / Barber Licensure - Remittance Unit
410 Capitol Ave., MS #12MOA
Hartford, CT 06134-0308