PHYSICIAN ASSISTANT LICENSURE

APPLICANT: PLEASE COMPLETE AND SIGN THIS INQUIRY FORM AND FORWARD IT TO THE FEDERATION OF STATE MEDICAL BOARDS, 400 FULLER WISER ROAD, EULESS, TX 76039.

DISCIPLINARY INQUIRY

THE CONNECTICUT DEPARTMENT OF PUBLIC HEALTH REQUESTS A DISCIPLINARY SEARCH CONCERNING THE FOLLOWING INDIVIDUAL:

NAME: _____
LAST FIRST MIDDLE MAIDEN

DEGREE _____

ADDRESS: _____
NO. & STREET CITY STATE ZIP CODE

DATE OF BIRTH _____/_____/_____

SOCIAL SECURITY NUMBER _____-_____-_____

PHYSICIAN ASSISTANT SCHOOL OF GRADUATION
_____
(INCLUDE COMPLETE NAME AND BRANCH LOCATION)

DATE OF GRADUATION _____

PLEASE MAIL THE RESPONSE TO THE FOLLOWING ADDRESS:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN ASSISTANT LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134

_____
APPLICANT SIGNATURE