

BOX 1

SOC. SEC. NO. [REDACTED] FED. EMPLOYER ID. NO. [REDACTED]
IF SOC. SEC. NO. IS MISSING OR DIFFERENT THAN ABOVE
PLEASE ENTER BELOW

TYPE
01

IF FED. EMPLOYER ID. NO. IS MISSING OR DIFFERENT THAN ABOVE
PLEASE ENTER BELOW

IF YOU HAVE NEITHER A S.S.N. NOR A F.E.I.N., INDICATE REASON

___ APP. FOR NO. PENDING

___ NOT U.S. CITIZEN ___ OTHER

BOX 2 Make Any Changes or Corrections in Box 4

0008684 FP **PRSRT T6 O 0763 06525
HENRY J. NUSBAUM, MD
23 TULIP TREE LANE
WOODBRIIDGE CT 06525

BOX 3 YOU MUST RENEW YOUR LICENSE/CERTIFICATE BY THE DUE DATE INDICATED. LICENSE/CERTIFICATE NUMBER
RENEWAL FEE: \$565.00 DUE DATE 05/31/10 034445

Profession: PHYSICIAN/SURGEON
BOX 4
Print or Type
Changes in Space Provided At The Right
LAST NAME (101)
FIRST NAME (102) MI (103)
ADD 1 (111)
ADD 2 (112)
ADD 3 (113)
CITY (114) ST (115)
ZIP (116) COUNTRY

Check appropriate address box: Office Residence

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION
POST OFFICE BOX 1080 HARTFORD, CT 06143-1080

4403444501565000531201000044148554

INSTRUCTIONS ANSWER EACH QUESTION, READ THE STATEMENTS THAT FOLLOW AS THEY RELATE TO YOUR LICENSE, AND SIGN BELOW.

- 1. WITHIN THE LAST YEAR HAVE YOU BEEN CONVICTED OF A FELONY OR HAVE YOU HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU OR ANY SUCH ACTIONS PENDING BY ANOTHER STATE'S LICENSURE/CERTIFICATION AUTHORITY? NO ___ YES ___
- 2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO ___ YES ___ HOURS OF PRACTICE PER WEEK 70
- 3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 41 BREWSTER RD BRISTOL, CT 06011
CITY BRISTOL STATE CT ZIP 06011 TYPE OF AGENCY HOSPITAL PHONE # 860 585 3295
- 4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 23 TULIP TREE LANE CITY WOODBRIDGE STATE CT ZIP 06525
PHONE # 203 387 4023
- 5. HIGHEST DEGREE HELD MD, PhD
- 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE

↓ DO NOT WRITE IN THIS AREA ↓

020001 0108 0215 01 034445 0056500 031610 5

- 7. IF YOU ARE AN OPTOMETRIST, ARE YOU QUALIFIED TO HOLD YOURSELF OUT AS AUTHORIZED TO PRACTICE ADVANCED OPTOMETRIC CARE? ___ YES ___ NO
- 8. IF YOU ARE AN EMT, EMT-I, OR MRT, OR HOLD A LICENSE/CERTIFICATE IN A LEAD OR ASBESTOS DISCIPLINE, PROVIDE REFRESHER COURSE COMPLETION DATE ___ AND COURSE APPROVAL NUMBER ___
- 9. IF YOU ARE A CHIROPRACTOR, DENTAL HYGIENIST, OCCUPATIONAL THERAPIST OR ASSISTANT, OPTICIAN, OPTOMETRIST, OR SOCIAL WORKER, YOU MUST COMPLY WITH MANDATORY CONTINUING EDUCATION REQUIREMENTS FOR LICENSE RENEWAL. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE RNs MUST MAINTAIN CERTIFICATION FROM THE NATIONAL CERTIFYING BODY THAT QUALIFIED THEM FOR INITIAL LICENSURE, IN ORDER TO RENEW SUCH LICENSES.
- 10. IF YOU ARE LICENSED AS AN APRN, DENTAL HYGIENIST, CHIROPRACTIC, NATUROPATHIC, PODIATRIC, OSTEOPATHIC OR HOMEOPATHIC PHYSICIAN, OPTOMETRIST OR PHYSICIAN/SURGEON WHO PROVIDES DIRECT PATIENT CARE SERVICES, YOU MUST MAINTAIN PROFESSIONAL LIABILITY INSURANCE OR OTHER INDEMNITY AGAINST LIABILITY FOR PROFESSIONAL MALPRACTICE, IN ACCORDANCE WITH CT GENERAL STATUTES.

I HAVE REVIEWED THE INFORMATION PROVIDED AND REQUESTED ON THIS CARD. I VERIFY THAT IT IS ACCURATE AND THAT I SATISFY THE REQUIREMENTS LISTED ABOVE AS THEY APPLY TO MY LICENSE/CERTIFICATE.

SIGNATURE Henry J. Nusbaum

DATE 14 MAR 2010

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LICENSE/CERTIFICATE NUMBER: 034445

Profession: **PHYSICIAN/SURGEON**

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Print or Type Changes in Space Provided At The Right

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FIRST NAME (102) _____ MI (103) _____

ADD 1 (111) _____

ADD 2 (112) _____

ADD 3 (113) _____

CITY (114) _____ ST (115) _____

ZIP (118) _____ COUNTRY _____

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION
POST OFFICE BOX 1089 HARTFORD, CT 06143-1089

4403444501565000531201100052727340

INSTRUCTIONS ANSWER EACH QUESTION, READ THE STATEMENTS THAT FOLLOW AS THEY RELATE TO YOUR LICENSE, AND SIGN BELOW.

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2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO _____ YES HOURS OF PRACTICE PER WEEK 75
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 41 BREWSTER RD BRISTOL CT 06011
CITY BRISTOL STATE CT ZIP 06011 TYPE OF AGENCY HOSPITAL PHONE # 860 585 3245
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020002 0042 0083 01 034445 0056500 031511 S

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SIGNATURE Henry J. Nusbaum

DATE 13 MAR 2011