Print Form

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

CERTIFICATE BY THE DIRECTOR

THIS IS TO CERTIFY THAT I HAVE ACCEPTED THE POSITION OF

DIRECTOR FOR Progressive Institute, LLC

LOCATED AT 2 Trap Falls Rd. Suite 120, Shelton, CT 06484

In accepting this position, I agree to assume responsibility for the above facility in accordance with the Public Health Code of the State of Connecticut and all applicable Connecticut General Statues.

Please attach a currently updated resume.

DIRECTOR'S NAME (PLEASE PRINT) _____ DIRECTOR'S SIGNATURE _____

RESIDENCE ADDRESS _____ HOME TELEPHONE NUMBER _____

CITY OR TOWN _____ STATE _____ ZIP CODE _____

AFFIDAVIT

_____ personally appeared and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

Subscribed and sworn before me this _____ day of _____ , 20_____ .

_____

Notary Public	[ ]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of Superior Court	[ ]

My commission expires: _____
(If Notary Public)

Phone: (860) 509-7400 Fax: (860) 509-7538
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer