OC. SEC. NO. FED. EMPLOYER ID. NO.

SOC. SEC. NO IS MISSING OR DIFFERENT THAN ABOVE
PLEASE ENTER BELOW

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

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

___ APP. FOR NO. PENDING

___ NOT U.S. CITIZEN ___ OTHER ___

TYPE 10

BOX 3 YOU MUST RENEW YOUR LICENSE/CERTIFICATE BY THE DUE DATE INDICATED.

RENEWAL FEE: $50.00 DUE DATE 11/30/05

LICENSE/CERTIFICATE NUMBER E56160

Profession REGISTERED NURSE

BOX 2 Make Any Changes or Corrections in Box 4

0010035 FP **PRSRT T3 0 0963 32818
ORPHIA S. WILSON RN
7012 CORAL COVE DRIVE
ORLANDO FL 32818

BOX 4 Print or Type Changes to Address Provided at Left

LAST NAME (101) WILSON
FIRST NAME (102) ORPHIA MI (103) S
ADD 1 (111) 48 Southwood Dr
ADD 2 (112)
ADD 3 (113)
CITY (114) Windsor ST (115) CT
ZIP (116) 06095 COUNTRY USA

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

44X561601005000113020056

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 IN 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 40

3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 55 Grand St
CITY New Britain STATE CT ZIP 06051 TYPE OF AGENCY Nursing PHONE # 223-3617

4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 48 Southwood Dr CITY Windsor STATE CT ZIP 06095
PHONE # 860-794-0439

5. HIGHEST DEGREE HELD A.S 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE

020005 0003 0005 10 E56160 0005000 093305 S (DO NOT WRITE IN THIS AREA)

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.

Orphia Wilson
SIGNATURE

9-20-05
DATE

10-5-04

BOX 1

SOC. SEC. NO. FED. EMPLOYER ID. NO.

IF SOC. SEC. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW

___ ___ ___ - ___ ___ - ___ ___ ___ ___

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 ____

TYPE 10

BOX 3 YOU MUST RENEW YOUR LICENSE/CERTIFICATE BY THE DUE DATE INDICATED.

RENEWAL FEE: $50.00 DUE DATE 11/30/04

LICENSE/CERTIFICATE NUMBER E56160

Profession REGISTERED NURSE

BOX 2 - Make Any Changes or Corrections in Box 4

0009808 FP **PRSRT T6 0 0963 32818
ORPHIA S. WILSON RN
7012 CORAL COVE DRIVE
ORLANDO FL 32818

BOX 4 Print or Type Changes in Space Provided At The Right.

LAST NAME (101)	Wilson
FIRST NAME (102)	Orphia MI (103)
ADD 1 (111)	7012 Coral Cove dr
ADD 2 (112)	
ADD 3 (113)	
CITY (114)	Orlando ST (115) FL
ZIP (116)	32818 COUNTRY USA

No changes ✓

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

44X561601005000113020043

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 40
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 1200 Fairbanks Rd CITY Winter park STATE FL ZIP ____ TYPE OF AGENCY Nursing PHONE # 407-298-8820
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 7012 Coral Cove dr CITY Orlando STATE FL ZIP 32818 PHONE # 407-292-8667
5. HIGHEST DEGREE HELD A.S. 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, N/A

020000000100081 10 E56160 0005000 100504 5

DO NOT WRITE IN THIS AREA

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 OR 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: Orphia W... DATE: 9/4/04

11-17-03

SOC. SEC. NO. FED. EMPLOYER ID. NO.

IF SOC. SEC. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW

___-__-____

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 ________

TYPE 10

RENEWAL FEE: 50.00 DUE DATE 11/30/03 E56166

Profession RN

BOX 2 — Make Any Changes or Corrections in Box 4

Orphia S. Wilson
5 Broadview Place
Windsor, CT 06095

Check appropriate address box: ☐ Office ☐ Residence

BOX 4 Print or Type Changes in Space Provided At The Right

LAST NAME (101) Wilson

FIRST NAME (102) Orphia MI (103)

ADD 1 (111) 7012 Coral Cove Dr

ADD 2 (112)

ADD 3 (113)

CITY (114) Orlando ST (115) FL

ZIP (116) 32818 USA COUNTRY

M.G. 11/17/03

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

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 40
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 200 Fairbank Rd CITY Winter Park STATE FL ZIP ____ TYPE OF AGENCY Pedictric
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 7012 Coral Cove CITY Orlando STATE FL ZIP 32818 PHONE # ____ PHON

32818

5. HIGHEST DEGREE HELD H.S
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 ↓

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

E56166 5A 03 031117 100 056

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]
SIGNATURE

11-17-03
DATE

16