1ST NURSE REGISTRY

CONSENT FOR PROFESSIONAL LIABILITY OR MALPRACTICE INSURANCE CONFIRMATION

To Whom It May Concern:

I give, _____ my insurance Broker, authorization to release to my employer the following information:

- Professional Liability or Malpractice insurance policy information;
- Copies of professional liability or malpractice policies and certificates of insurance.

I also give authorization to advise my employer of any changes in my professional liability or malpractice insurance.

I am aware and acknowledge the information referred to above is not shared with any third parties except the employer if requested at any time for audit. The information is used by the employer to confirm adequate and proper insurance coverage of during the course of my employment. By signing below I give the employer consent to collect the information contained herein and use for the purpose specified. By signing below I also give consent to my insurance broker to provide the employer with the above-mentioned information.

Signed _____

Print Name _____

Address _____

_____

_____

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