

1<sup>ST</sup> NURSE REGISTRY

**CONTRACTOR/EMPLOYEE CONSENT FOR  
INSURANCE CONFIRMATION**

To Whom It May Concern:

I give, \_\_\_\_\_ my insurance

Broker, authorization to release to my employer the following information:

- Automobile insurance policy information;
- Copies of automobile policies and certificates of insurance.

I also give authorization to advise my employer of any changes in my automobile 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 my automobile while being used in 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 \_\_\_\_\_

2215 N. Military Trail, Suite O, West Palm Beach, FL 33409

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Email: Office@1stNurseRegistry.com