AUTHORIZATION FOR RELEASE OF MALPRACTICE INSURANCE INFORMATION

Please choose one of the following options:

- o I do not have liability or malpractice insurance. (Sign and date below)

- o I do have liability or malpractice insurance (Complete malpractice statement below)

Malpractice Statement:

To Whom It May Concern,

I, _____, hereby consent to the North Carolina Board of Pharmacy and its employees and/or agents examining and obtaining all records relating to my file with _____ related to claims, settlements, payments, and dismissals and/or any other documents maintained by this malpractice insurance carrier. I understand that by signing this document, the North Carolina Board of Pharmacy may review the information contained in these files in conjunction with the review process for my application for approval as a Clinical Pharmacist Practitioner.

Date: _____

Signature: _____

Street Address: _____

City, State, Zip: _____

Phone number (include area code): _____