

# Insured by Employer Confirmation

This form confirms you have professional liability insurance through your employer.



## Membership Applicant / Member Information

Full Name:	
Address:	
Position Title at Workplace:	
Telephone:	Email:

## Employer Information

Full Name:	
Address:	
Telephone:	Email:

Note: If you are accepted as a member of the College and you decide to engage in private practice, you must provide proof of purchase of professional liability insurance in the amount of \$2 million or more.

## Declaration

I confirm that I have professional liability insurance through my employer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Membership Applicant/Member*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Employer*

Please submit this form by mail or email:

College of Licensed Counselling Therapists of New Brunswick  
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