



Insured by Employer Confirmation

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

Membership Applicant/Member Information

Name: _____

Address: _____

Position Title at Workplace: _____

Telephone: _____ Email: _____

Employer Information

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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