The following information is required before we can process your request for information pertaining to the UMDNJ's Professional and General Liability Program of Self-Insurance.

TO BE COMPLETED BY INSURED OR FORMER INSURED

School Association (check were appropriate)

N.J. Medical School _____ Rutgers Medical School _____

Robert Wood Johnson Medical School _____ School of Osteopathic Medicine _____

_____ Position(s) held at UMDNJ (i.e.: clinical faculty member, resident, intern, etc.)

_____ Dates of association (ex: 7/1/90-7/1/91)

_____ Clinical Specialty

Authorization to be Signed by Insured

I hereby authorized UMDNJ to furnish _____ with professional liability loss experience information pertaining to the period of _____ through _____. I hereby hold harmless and release The State of N.J., University of Medicine and Dentistry of N.J., and its employees and agents from any and all liability or damages which might arise as a result of the release of said loss experience information by the UMDNJ Professional and General Liability Program of Self-Insurance.

_____ _____

Signature Current Address

_____ _____

Name (printed or typed)

_____ _____

Date

FAX DIRECTLY TO (973) 972-7257