



FORM 1: CERTIFICATE OF ACCEPTABLE MALPRACTICE INSURANCE

(Please Print)

To: The Saskatchewan College of Pharmacists (the "College")

I, _____, of the city/town of _____, in the Province of _____, hereby certify that:

1. I have current acceptable malpractice insurance within the meaning of section 4.4.4 of the Bylaws of the College on one of the following two basis (please check the applicable one):
 - I have acceptable malpractice insurance through the Pharmacists' Association of Saskatchewan (PAS), in which case I expressly authorize the PAS to release any and all information as the College considers reasonably necessary from time to time to verify the existence and maintenance of such insurance; or
 - I have acceptable malpractice insurance through _____ (insert name of insurance provider), and have attached a copy of the applicable certificate of insurance.
2. If at any time:
 - (a) I fail to continuously maintain acceptable malpractice insurance or otherwise cease to be insured pursuant to a policy providing acceptable malpractice insurance; or
 - (b) being a member of the PAS, I cease to be a member of the PAS;
 I will immediately report that fact to the Registrar-Treasurer.
3. I understand that it is professional misconduct for a member to:
 - (a) provide false or misleading information to the Registrar-Treasurer in connection with the matters contemplated in Bylaw 4.4.4;
 - (b) practise, or continue to practise pharmacy without first obtaining and continuously maintaining acceptable malpractice insurance; or
 - (c) fail to immediately notify the Registrar-Treasurer if for any reason the member, being a practising member, fails to continuously maintain acceptable malpractice insurance or otherwise ceases to be insured pursuant to a policy providing acceptable malpractice insurance.
4. I hereby authorize my insurance carrier to provide a 30-day notice of cancellation or amendment of coverage to the Saskatchewan College of Pharmacists (the "College") should such cancellation be requested or any change in coverage be incorporated.

Dated this _____ day of _____, 20____, at the city/town of _____, in the Province of _____.

Signature _____

SCP Member # _____

PLEASE ENSURE THAT YOU HAVE COMPLETED THE ENTIRE FORM