



FORM 1: CERTIFICATE OF ACCEPTABLE MALPRACTICE INSURANCE

(Please Print)

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

I, _____, of the _____ of _____, in the Province
of _____, hereby certify that:

1. I: am (please check appropriate box)
 am not

a member of the Pharmacists' Association of Saskatchewan (the PAS) (formerly the Representative Board of Saskatchewan Pharmacists).

2. 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 am a member of the PAS and have acceptable malpractice insurance by virtue of such membership, 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 am not a member of the PAS and **attached to this certificate is a true copy of the certificate of insurance evidencing the said acceptable malpractice insurance.**

3. 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.

4. 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.

5. 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 _____
of _____, in the Province of _____.

Signature

SCP Member #

PLEASE ENSURE THAT YOU HAVE COMPLETED THE ENTIRE FORM