

CONSENT TO RELEASE CLAIMS HISTORY

Graduate's Name (please print): _____

Alias (Maiden, Previous Married Name) Used During Enrollment at Wilkes University:

Wilkes Identification Number (WIN) or last four digits of your SSN: _____

Current Address: _____

Email: _____

Telephone: _____

Years Enrolled: _____ Clinical Dates _____

Degree(s): _____

I, the above listed Wilkes University graduate, authorize Wilkes University to request release of confirmation of my student professional liability coverage and any related claims history to the institution listed below. I understand that Wilkes University will be requesting and obtaining the information from third parties and thus cannot be responsible for the timeliness, accuracy or completeness of the information provided. I release and hold harmless Wilkes University with regard to any claims or liability that may result from response to this request, or failure to act on this request, by Wilkes University or the professional liability insurance carrier(s).

Name: _____

Address: _____

Telephone: _____

E-mail: _____

Date

Graduate's Signature