

# BELMONT UNIVERSITY SCHOOL of PHARMACY

## Student Enrollment Form

### Individual Professional Liability Insurance

*Please type or print the following information.*

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Permanent Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Number  Cell Phone

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School E-mail address:

\_\_\_\_\_  
Personal E-mail address:

Current Year:  P1  P2  P3  Other \_\_\_\_\_ Projected Date of Graduation \_\_\_\_\_

Program  PharmD

Are you a registered pharmacist?  Yes  No

*Registered pharmacists are not eligible for this program. Please contact our office for additional options.*

I have a current Individual Pharmacists Professional Liability Policy with Pharmacists Mutual.

Please terminate Policy # PHL \_\_\_\_\_ (indicate policy #, if known)

\_\_\_\_\_  
Signature of Enrollee

\_\_\_\_\_  
Date

*(Please return this completed form to the College of Pharmacy office.)*

Belmont University School of Pharmacy - Customer #0007288801

CSP # \_\_\_\_\_