



New York State Partnership for Long-Term Care

AGENT TRAINING INFORMATION RELEASE

I grant permission to the New York State Partnership for Long-Term Care (the Partnership) to use the following information, for use on the Partnership website, or other electronic form or media to announce my completion of the Mandatory Partnership agent training and certification:

- 1) Full Name
- 2) County (Office Location)
- 3) Insurance License Number

Posting and use of this information will occur only when all certification requirements have been successfully completed.

I hereby waive any right to inspect or approve a format or language associated with the above-listed information that may be used in conjunction with the announcement of the agent training now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the information.

I hereby agree to release and hold harmless the Partnership, via electronic or other media, from and against any claims, damages or liability arising from or related to the use of the above-listed information.

I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Yes

No

(Please Print)

Name: _____

County: (Office Location) _____

Ins. License #: _____

Signature: _____ Date: _____

<p>Office Use Only: Cert #: _____</p>
