MARYLAND MEDICINE COMPREHENSIVE INSURANCE PROGRAM
Request For Insurance Coverage At Offsite Location(s)
University of Maryland School of Medicine

PURPOSE: To comply with underwriting requirements of the professional liability program. For use by active, enrolled medical students in good standing, for activities associated with the program of education and training under the authority of the University of Maryland School of Medicine, at locations not owned or operated by an insured entity - UMMSC, UPI, practice plan.

SECTION I - to be completed by Medical Student

1. Medical Student’s Name ________________________________________________
2. Medical Student’s Email Address _________________________________________
3. Current Training Year ___________________________________________________
4. Name of Off Site Location:
   Address: ___________________________________________________________________
   City: __________ State: _______ Country: ___________ Zip Code: __________
5. Dates of this elective or extracurricular rotation: Start Date: __________ End Date: __________
   Number of hours at location: _______ per (circle one): week month year
6. Purpose/Objective of Rotation:

7. Activity involves: (circle one) Direct Patient Care Purely Observational Other: __________
8. Are all of the activities clearly within the scope of your educational training program at U of MD SOM?
   Yes _____ No _____ If not, please explain: _____________________________________________
9. Who will be supervising your activity? UM,B SOM faculty ______ Offsite location physician _______
   Other ________________________________
10. Is verification of your coverage needed at location? Yes _____ No _____

   Applicant's/Medical Student’s Signature     Date

SECTION II  To be completed by Office of Student Affairs, University of Maryland School of Medicine

12. Please confirm if the activity is an ELECTIVE or EXTRACURRICULAR (circle one).
13. Do these activities fulfill educational requirements of the curriculum at U of MD SOM (i.e., for credit) ?
   Yes _____ No _____
14. Have you authorized these activities at this location? Yes _____ No _______

   Signature of Associate Dean for Student Affairs     Date

Printed Name of Associate Dean for Student Affairs