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