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| **Stanford Health Care & Stanford Children’s Health** **Malpractice Insurance Coverage Request (Certificate of Insurance)** | **Today’s Date:** |  |
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| **Please complete the following to request a certificate of insurance for SUMIT Insurance Company to extend malpractice insurance to individuals working outside approved practice sites.**  |
| * **One form must be completed for each request. Incomplete requests will be returned.**
 |
| * **An approved contract or support documentation MUST be attached / included.**
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|  |
| **Requestor (Person Completing Form):** |
| Name: |  | **Department:** |  |
| Email: |  |  | **Phone Number:** |  |
|  |
| **Provider Information:** |
| **Provider Name:** |  | **Select:** | [ ]  SHC | [ ]  LPCH | [ ]  Research |
| **Provider Type:** | [ ]  MD | MD ID#: |  | [ ]  RN | [ ]  Allied (NP, PA) | [ ]  Medical Student |
| **If MD, Last Medical Staff Appointment:** |  | **Expiration Date:** |  |
| **If MD, Last Faculty Appointment:** |  | **Expiration Date:** |  |
| **Describe the activities for which insurance is requested:** |  |
|  |
| **Why won’t outside organization provide coverage?** |  |
|  |
| **Will activity be carried out on a repeat basis?** **[ ]**  Yes **[ ]**  No | If No, One Time Date: |  |
| **Dates of Activity:**  | Start: |  | End:  |  |
| **Does this activity generate income for SHC/LPCH?** **[ ]**  Yes **[ ]**  No |
| **Is there a contract with this institution? [ ]**  Yes **[ ]**  No  | Coverage amount specified in contract: |  |
| Contract / Documentation attached [ ]  Yes [ ]  No CONTRACT MUST BE ATTACHED |
|  |
| **Name and address of Facility where clinical care will be rendered by this provider** **(or if clinical trial research use sponsor address):**  |
| **Facility Name:** |  | **Contact:** |  |
| **Address:**(city, state, zip code) |  |
|  |
| **Approvals: Both department chair and hospital approval is required for off-site services.** |

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| **Department Chair:** By signing below you are confirming that the above named physician’s participation in patient care services at the described facility is within their course and scope of employment in your department. |
| Print: | Sign: | Date:  |
| **SHC or LPCH Hospital Administration:**  |
| Print: | Sign: | Date: |

|  |
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| **The Risk Authority:** |
| Print: | Sign: | Date: |
|  |  |
|  | **The Risk Authority:** |
| **Please email completed form to:** riskmanagement@stanfordhealthcare.org | Received: |  |
| Processing can take up to 5 business days. | Approved: |  |