|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Stanford Health Care & Stanford Children’s Health**  **Malpractice Insurance Coverage Request (Certificate of Insurance)** | | | | | | | | | | | | | | | | | | | | **Today’s  Date:** | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **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.** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **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.** | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **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: |

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