

**Malpractice Coverage Request for Residents on Approved Off Campus Electives**

**Stanford University Medical Indemnity and Trust (SUMIT) Insurance Co.**

**#57000026114**

**\*PLEASE FILL OUT FORM COMPLETELY. ACTION CANNOT BE TAKEN UNTIL FORM IS COMPLETE AND SIGNATURES OBTAINED.**

Please complete the following sections to request a certificate of insurance coverage for a SHC/LPCH resident to extend malpractice insurance coverage when working outside approved practice sites. **ONE FORM MUST BE COMPLETED FOR EACH RESIDENT. For processing questions, please call AON Risk Services at 1-866-283-7122.**

**Name of Resident for Whom Insurance is Requested:** \_\_\_\_\_

Describe the Activities for Which Insurance is Requested : \_\_\_\_\_

\_\_\_\_\_

Will activity be carried out on a repeated basis?  No  Yes ---Frequency? \_\_\_\_\_ (days per wk or per month)

Date(s) of activity: Start Date \_\_\_/\_\_\_/\_\_\_ to End Date \_\_\_/\_\_\_/\_\_\_ **OR** one time only date: \_\_\_/\_\_\_/\_\_\_

**Name and Address of Facility Where Clinical Care Will Be Rendered by This Resident Under the Supervision of A Practicing Physician (NOTE: coverage is only for the resident, NOT for the supervision exposure by the physician):**

\_\_\_\_\_  
(Name of Facility) (Supervising Physician) (Phone #)

\_\_\_\_\_  
(Mailing Address) (City, State, Zip Code)

**Should Certificate of Insurance be sent directly to this supervisor?**  Yes  No, to whom? \_\_\_\_\_

Please check all that apply:

SHC\_\_\_ LPCH\_\_\_ Training/Specialized Education \_\_\_ Research\* \_\_\_

(\* If this is Research/School of Medicine it must be forwarded to the Stanford University Risk Management Department via fax: 3-9456)

**Graduate Medical Education: Please complete and send by fax to AON RISK SERVICES at 1-847-953-5390**

*Please confirm by signature below that the above named resident's participation in patient care services at the described facility is within the course and scope of his/her residency within the SU program. Thank you.*

Yes  No \_\_\_\_\_  
(Chief of Staff's Signature & Date) (Please Print Name)

\_\_\_\_\_  
(GME Director Signature & Date)

**GME Dept. Contact (for questions): Ann Dohn, Director 650-723-5948**

**Please also fax a copy to Risk Management Insurance Analyst at 650- 736-2495.**