

REQUEST FOR VERIFICATION OF  
PROFESSIONAL LIABILITY INSURANCE

Date \_\_\_\_\_

Name of Person to be Insured \_\_\_\_\_

Department \_\_\_\_\_

Dates of Coverage \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

Supervisor's box #, phone #, and email address

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Supervisor's Signature \_\_\_\_\_

Institution's Name and Address

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Contact Person \_\_\_\_\_

Contact Person's phone # and email address

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