Please type

Louisiana State University Health Sciences Center in Shreveport
REQUEST FOR MEDICAL MALPRACTICE VERIFICATION

DATE: ___________________________    Please check one:
NAME: ___________________________
TITLE: ___________________________
DEPARTMENT: ______________________    DATE OF EMPLOYMENT: ______________________

☐ Faculty Member
☐ House Officer
☐ Student
☐ Nurse

I am requesting that a letter verifying my medical malpractice coverage be sent to the following (Please indicate the name of the institution(s) and correct mailing address(es). Attach a list if multiple letters are requested. If additional space is needed attach a separate sheet.):

I expect to provide the following service(s) (Please indicate briefly the capacity of your association, type of procedure(s), and expected duration with the hospital, clinic, or organization. If additional space is needed attach a separate sheet.):

________________________________________

Signature

FOR FACULTY USE ONLY

I hereby certify that all income derived from my association with this hospital, clinic, or organization will be handled through the provisions of the appropriate faculty income plan.

________________________________________

Signature

★ IMPORTANT: Faculty members must sign.

Approved by:

________________________________________    ______________________________________
Department Head                             Coordinator of Legal Affairs

Revised July 1999