Please type

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

DATE: _____

NAME: _____

TITLE: _____

Please check one:
- ❑ Faculty Member
- ❑ House Officer
- ❑ Student
- ❑ Nurse

DEPARTMENT: _____ DATE OF EMPLOYMENT: _____

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