



System Office of Risk Services

910 Yukon Dr. · 106 Butrovich Building · PO Box 755240 · Fairbanks, AK 99775-5240
 Office (907) 450-8157 or (907) 450-8150 -- Fax (907) 450-8151

STUDENT PROFESSIONAL LIABILITY INSURANCE APPLICATION FORM
 (For Use of University of Alaska Students Only)

Department _____ Campus: UAA UAF UAS
 Course Name _____ Course #s _____
 Person to Contact at Department _____ Phone _____
 Org & Fund # to be Charged for Premium _____
 Coverage Effective Date: _____ Through _____

Coverage is not in effect until signed and approved application is received by SORS.

Limits of Liability	Student Premium	X	Number of Students	=	Premium
\$1,000,000/\$5,000,000 Pays up to a total of \$1,000,000 per claim, \$5,000,000 per policy year	Annual \$12.35	X	_____	=	\$ _____

Indicate the maximum number of students to be insured in each course.

_____ Art Therapist	_____ Enterostomal Therapist	OT
_____ Athletic Trainer	_____ Exercise Physiologist	_____ Occupational Therapist
_____ Audiologist	_____ Exercise Science	_____ Occupational Therapist Asst.
_____ Bio-Medical Tech.	_____ Forensic Science Intern	_____ Optometry Tech/Asst.
_____ Blood Bank Tech.	_____ Gerontology	_____ Orthopedic Assistant
_____ Cardiology Tech.	_____ Health Care/Services Admin.	_____ Patient Care Technician
_____ Cardiovascular Tech.	_____ Health Educator	_____ Pedorthist
_____ Certified Laboratory Tech.	_____ Health Science	_____ Perfusionist
_____ Certified Medical Assistant	_____ Histologic Tech.	_____ Personal Trainer/Health Fitness
_____ Certified Medical Aide	_____ Hospital Pharmacy Tech.	_____ Pharmacist
_____ Child Development and/or Family Services	_____ Human Services	_____ Pharmacist Assistant/Tech.
_____ Chiropractic Assistant	_____ Interpreter for the Deaf	_____ Phlebotomist
_____ Circulation Technician	_____ Kinesiologist/Kinesiotherapist	_____ Physical Therapist
_____ Clinical Laboratory Tech.	_____ Laboratory Aide	_____ Physical Therapist Assistant
_____ Community Health Assistant	_____ Laboratory Tech.	_____ Podiatric Assistant
_____ Community Health Tech.	_____ Massage Therapist	_____ Psychologist/Psychotherapist
_____ Corrective Therapist	_____ Medical Assistant	_____ Radiation Therapist
_____ Cosmetologist	_____ Medical Laboratory Tech.	_____ Radiologic Tech.
Counselor	_____ Medical Tech.	_____ Recreation Therapist
_____ Alcohol/Drug	_____ Medical Tech. Assistant	_____ Rehabilitation Assistant
_____ Marriage & Family	_____ Medical Records Administrator	_____ Rehabilitation Therapist
_____ Pastoral	_____ Medical Records Tech.	_____ Renal Dialysis Tech.
_____ Personnel and/or Guidance	_____ Medical Retardation Work	_____ Respiratory Car Provider
_____ School	_____ Medical Technologist	_____ Respiratory Therapist
_____ Wellness	_____ Medication Preparation Tech.	_____ Respiratory Therapist Tech.
_____ Clinical/Rehabilitation/Mental Health	_____ Music Therapist	_____ Social Worker
_____ Dance Therapist	_____ Nuclear Medical Tech.	_____ Speech Hearing Therapist
_____ Dental Assistant	Nurses	_____ Speech-Language Pathologist
_____ Dental Hygienist	_____ RN	_____ Sports Medicine Instructor
_____ Dental Laboratory Tech.	_____ Home Health Aide	_____ Sports Medicine Therapist
_____ Diagnostic Medical Sonographer	_____ LPN/LVN	_____ Surgical Assistant
_____ Dialysis Tech.	_____ Nurses Aide	_____ Veterinary Tech.
_____ Dietician	_____ Nursing Asst.	_____ X-Ray Machine Operator
_____ EEG Tech.	_____ Geriatric Nursing Asst.	_____ Sports Medicine Therapist
_____ EKG Tech.	Nurse Practitioners	
_____ Electrologist	_____ Geriatric/Adult or Family Planning - GYN	_____ Other – _____
EMS	_____ Psychiatric	(Please list and provide curriculum for review)
_____ Paramedic	_____ Pediatric/Family Practice/Neonatal	
_____ Basic/Intermediate	_____ OB/GYN	
_____ Emergency Medical Tech.	_____ Nutritionist	
_____ First Responder		
		_____ Total # of Students

UA STUDENT PROFESSIONAL LIABILITY INSURANCE APPLICATION FORM – Continued

COVERAGE WILL BECOME EFFECTIVE FOLLOWING THE RECEIPT OF YOUR ACCEPTABLE APPLICATION. PLEASE PROCESS YOUR REQUEST FOR INSURANCE TO THE SYSTEM OFFICE OF RISK SERVICES AT LEAST 15 DAYS IN ADVANCE OF COVERAGE DATE. YOUR APPLICATION CANNOT BE PROCESSED UNLESS IT IS COMPLETED IN ITS ENTIRETY. THE COMPLETED FORM MAY BE FAXED TO 450-8151.

1. Have any professional liability claims or suits been brought in the past five years against the school or any insured student concerning the specialties to be insured? No Yes (If yes, provide details on a separate sheet and attach.)
2. Do you have in place a formal risk management program for your students (i.e., universal precautions, legal issues/education or similar requirements)? No Yes
3. What is the percentage of your faculty who have been on staff one year or less? _____
4. What is the average time (in years) your faculty members remain on staff? _____
5. What is the percentage of faculty members who are pursuing continuing education? (For the designated curriculum(s) selected).

This program is not available to students training to be physicians, dentists, nurse anesthetists, nurse midwives, chiropractors, or podiatrists. Also you are not covered for the administration or the operation of motor-driven vehicles.

This insurance is subject to the terms, conditions, and exclusions of the insurance policy.

Coverage terminates upon graduation if graduation occurs before policy term expires.

I declare the information contained in the application is true and that no material facts have been suppressed or misstated. I understand that incorrect information could void the protection. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Signature of Department Head: _____ Date: _____

Printed Name: _____ Title: _____