Attachment A

DEPARTMENT OF NURSING & RESPIRATORY THERAPY
HEALTH INSURANCE FORM

Verification of Medical Insurance for __________ (Semester) ________ (Year)

Student's Name (print): ____

Insurance Company: ____

Name of Insured (name on card): ____

Contract #: ____

Group #: ____

Effective date: ____

I certify that the above information is accurate and true. I am fully covered with medical insurance that extends through the end of this semester. I understand if I purchase insurance with a monthly payment, I will provide the Department of Nursing with a monthly receipt. If this insurance status changes before the end of the semester, I will notify my course coordinator and will purchase additional insurance immediately. **I understand I cannot attend clinicals unless I am covered with medical insurance. Failure to continue insurance until the end of the semester could result in dismissal from the program.**

Signature of student: ____

Date: _________________ Verified By: ________________________________