

**REQUEST FOR VERIFICATION OF UMB STUDENT
PROFESSIONAL MALPRACTICE COVERAGE AND /OR CLAIMS
HISTORY**

Date:

GRADUATE'S NAME

GRADUATE'S UMB STUDENT ID NUMBER:

LAST:

MIDDLE:

FIRST:

ALIAS (MAIDEN, PREVIOUS MARRIED NAME) USED DURING
ENROLLMENT AT UMB:

IF SUPPLYING ALIAS, ATTACH PROOF OF NAME CHANGE.

GRADUATE'S DATE OF BIRTH:

GRADUATE'S CURRENT ADDRESS

STREET:

CITY, STATE, ZIP:

PHONE NUMBER:

GRADUATE'S CURRENT E-MAIL ADDRESS:

SCHOOL / DEPARTMENT ATTENDED/ GRADUATED

SCHOOL:

DEPARTMENT:

YEARS ENROLLED:

DEGREES:

EMPLOYER/INSTITUTION REQUESTING INFORMATION

NAME:

ADDRESS:

CITY, STATE, ZIP:

CONTACT PERSON:

PHONE:

I, the above listed UMB graduate, authorize UMB to request release of confirmation of my student professional liability (malpractice) coverage and any related claims history to the institution listed above. I realize that UMB will be requesting and obtaining the information from third parties and thus cannot be responsible for the timeliness, accuracy or completeness of the information provided. I release and hold harmless UMB and the State of Maryland with regard to any claims or liability that may result from response to this request, or failure to act on this request, by UMB, the State of Maryland, or the Maryland Medical Center Insurance Program.

Signature

Date

Please mail or fax the **signed** completed form to:

Office of Risk Management
University of Maryland Baltimore
714 West Lombard Street
Baltimore, Maryland 21201
FAX: (410) 706-1520

Allow up to 21 days for processing.