



CERTIFICATE OF INSURANCE REQUEST FOR ACADEMIC INTERNSHIP

PLEASE FILL IN ALL BLANKS

(Student Name)

(Internship Provider)

Internship Start Date: ___/___/_____

Internship End Date: ___/___/_____

Internship Supervisor: _____ Telephone: (____)_____

Internship Work Address: _____
(street address)

(city, state, zip)

Academic Department: _____ Telephone: (____)_____

Academic Sponsor: _____ Telephone: (____)_____

Course Name & Number: _____ Academic Credits: _____

Does the provider pay the student during the period of the internship? YYYY/NNN

Does the provider pay for Workers' Compensation coverage for the student? YYYY/NNN

Health Insurance Coverage: () Self () Student Health () Parents/spouse () Other

Provider name: _____

Policy Number: _____

Expiration Date: _____

**DO NOT SIGN THIS FORM UNTIL YOU HAVE COMMUNICATED WITH
FRANK HAMMITT, Risk Management, at 262-3525!**

You will need to contact him and discuss workers compensation *prior* to signing.

I have discussed requirements for reporting an accident or injury while on the job at the internship site with UCCS Department of Public Safety/Risk Management.

(student signature) _____ / ____ / ____
(date)