

**STUDENT ALLIED HEALTH LIABILITY INSURANCE
(PROFESSIONAL AND GENERAL LIABILITY)
COST: \$15.00 PER YEAR**

Student Name: _____ WSU ID #: _____

Academic Department: **NURS:** BSN [] RN-BSN [] MN/DNP [] PhD [] HPA []

NEP: UGrd [] CPD [] **PHARM** [] **SHS** []

Location: **Spokane** [] **TC** [] **WW** [] **VC** [] **Yak** []

Student Permanent Address: _____

Phone Number: _____ Email: _____

Request insurance to begin on: _____

(This policy is renewed annually and once paid, coverage for all related internships are covered for 365 days from this date)

This Student Allied Health Professional Liability Policy provides liability coverage of \$1,000,000 per occurrence with a \$3,000,000 annual aggregate limits and Commercial General Liability coverage with limits of \$1,000,000 per occurrence with a \$3,000,000 limits.

NURSING Students: Professional Liability Insurance is required for each student. Submit this form with payment of \$15.00.

NEP, SHS, & Pharm Students: Submit this form if requested by your department with payment of \$15.00.

When authenticated with the cashier's paid stamp and returned to your academic department, this document serves as proof of insurance. **Do not email the completed form! You may process this form in person in the Student Affairs Office (SAC 130) or mail it with payment to:**

Washington State University Spokane
Office of Student Affairs
Academic Center Rm 130
412 E Spokane Falls Blvd.
Spokane, WA 99202

Cashier's Paid Stamp

Check made payable to WSU [] **MasterCard** [] **Visa** []

Cardholder Name: _____

Billing Address: _____

Trans Code: ALLIEDIN

Card # _____ Security Code _____ Exp. Date _____

Authorization Signature: _____

WE ACCEPT THESE MAJOR CREDIT CARDS



PLEASE INCLUDE ALL INFORMATION. Omissions may result in your payment not being processed.