

Individual Liability Insurance Application for Students Internships



Privacy Notice: State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. Contact: esc@tamu.edu or (979) 845-4141.

INSTRUCTIONS Please complete this form with as much information as possible and follow instructions below for submittal.

DEPARTMENT INFORMATION

Department Name		
Intern Name	Phone	E-mail
Sponsoring Faculty Member Name	Phone	E-mail
Host Organization/Business		
Host Contact Person Name	Phone	E-mail
Start Date of Internship	End Date of Internship	

NATURE OF INTERNSHIP

<input type="checkbox"/> Art Therapist	<input type="checkbox"/> Enterostomal Therapist	<input type="checkbox"/> Optometric Technician
<input type="checkbox"/> Athletic Trainer	<input type="checkbox"/> Geriatric Nursing Assistant	<input type="checkbox"/> Optometrists
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Health Information Technologist	<input type="checkbox"/> Orthopedic Assistant
<input type="checkbox"/> Bio-Medical Technician	<input type="checkbox"/> Health Education	<input type="checkbox"/> Pastoral Counselors
<input type="checkbox"/> Blood Bank Technologist	<input type="checkbox"/> Hemodialysis Technician	<input type="checkbox"/> Personnel &/or Guidance Counselors
<input type="checkbox"/> Cardiology Technician	<input type="checkbox"/> Histologic Technician	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Certified Laboratory Assistant	<input type="checkbox"/> Hospital Pharmacist Technician	<input type="checkbox"/> Pharmacist Technician
<input type="checkbox"/> Child Care Assistant Programs	<input type="checkbox"/> Kinesiology/Applied Exercise Physio.	<input type="checkbox"/> Phlebotomist
<input type="checkbox"/> Child Development &/or Family Svcs	<input type="checkbox"/> Laboratory Aide	<input type="checkbox"/> Physical Therapist
<input type="checkbox"/> Clinical Laboratory Technologist	<input type="checkbox"/> LVN	<input type="checkbox"/> Physical Therapist Assistant
<input type="checkbox"/> Community Health Intern	<input type="checkbox"/> Long Term Healthcare Administration	<input type="checkbox"/> Psychiatric Technician
<input type="checkbox"/> Cosmetologist	<input type="checkbox"/> Marriage & Family Counselors	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Counselors	<input type="checkbox"/> Massage Therapist	<input type="checkbox"/> Radiologic Technologist
<input type="checkbox"/> C.O.T.A.	<input type="checkbox"/> Medical Assistant	<input type="checkbox"/> Recreational Therapist
<input type="checkbox"/> Dance Therapist	<input type="checkbox"/> Medical Laboratory Technician	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Dental Assistant	<input type="checkbox"/> Medical Technologist	<input type="checkbox"/> Rehabilitation Assistant
<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Medical Technical Assistant	<input type="checkbox"/> Respiratory Therapist
<input type="checkbox"/> Dental Laboratory Technician	<input type="checkbox"/> Mental Health Workers	<input type="checkbox"/> Respiratory Therapy Technician
<input type="checkbox"/> Diagnostic Medical Sonographer	<input type="checkbox"/> Music Therapist	<input type="checkbox"/> Social Workers
<input type="checkbox"/> Dietitian	<input type="checkbox"/> Nurses Aide	<input type="checkbox"/> Speech-Language Pathologist
<input type="checkbox"/> Drug & Alcohol Counselor	<input type="checkbox"/> Nursing Assistant	<input type="checkbox"/> Surgical Technologist
<input type="checkbox"/> EEG Technician	<input type="checkbox"/> Nuclear Medical Technologist	<input type="checkbox"/> Ultrasound Technologist
<input type="checkbox"/> EKG Technician	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Other
If Other, Explain.		

Signature of Department Head or Designee _____

Date _____

SUBMIT FORM TO:

Contract Administration-Insurance Services
Campus Mail Stop: 1182
Email: insurance@tamu.edu
Fax (979) 862-7130

NEED HELP?

Contract Administration – Insurance Services
Jason Boyle
(979) 845-0099
insurance@tamu.edu

INTERNAL USE ONLY

Date Received	Insurance Secured	<input type="checkbox"/>	Insurance Declined	<input type="checkbox"/>
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