MEDICAL INSURANCE VERIFICATION FORM

You must have current health insurance throughout your enrollment at the **University of St. Augustine for Health Sciences.**

Student name (please print): _____

I understand that it is my responsibility to maintain current continuous medical coverage (including hospitalization and emergency care) while enrolled at the University of St. Augustine for Health Sciences due to contractual agreements between the University and all clinical education sites. It is my responsibility to obtain and maintain coverage for all states where I attend school, as well as states in which I plan to practice during my clinical education experiences.

In consideration of my clinical education participation sponsored by the University, I hereby assume all responsibility involved with providing medical insurance coverage, and I indemnify, release, and hold harmless from all liability the University of St. Augustine for Health Sciences, its directors, officers, representatives, volunteers, participants, employees, students, and all other persons acting in any capacity on their behalf.

I understand that healthcare coverage is required so that I have access to necessary care should an incident occur on campus or in the clinical site that requires medical attention, because all healthcare costs are my responsibility. I have provided a copy of my health insurance card in order to acknowledge my understanding and responsibilities regarding healthcare coverage.

_____ _____

Signature Date

Please upload a copy of your current insurance ID card into CastleBranch, along with this form.