GRADUATE REQUEST FOR VERIFICATION OF STUDENT PROFESSIONAL LIABILITY COVERAGE

_____

Name (Please Print)

_____ _____

Dates of Attendance **Date of Graduation**

(Please check one)

_____ **General Liability Coverage Information**

_____ **Student Specific Information**

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Signature of Graduate

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Return Completed Form To:

Office of the Registrar **Fax To: 617 358-7551**

Boston University School of Medicine **or**
72 E. Concord Street, Room A414
Boston, MA 02118