EMAIL FORM TO: Risk Management: Gms35@Drexel.edu
Compliance: Compliance@Drexel.edu
Faculty Affairs: COM.FAFD@Drexel.edu

Professional Liability Coverage Request for Addition, Deletion or Change

SECTION A – GENERAL INFORMATION

Person Completing Form: _____

Department: _____

If adding physician, complete all sections of form.
If deleting physician, complete Sections A & E

If changing scope of work, complete Sections A, B, D & E
If adding a location, complete Sections A, C & E
If changing hours, complete Sections A & D & E

☐ ADD ☐ CHANGE ☐ DELETE

Effective Date: _____

* If deletion or addition, the effective date must match employment hire or termination date. *

PHYSICIAN NAME: _____

LICENSE NUMBER: _____

COLLEGE/DEPARTMENT: _____

SPECIALTY: _____

SECTION B - SCOPE OF WORK

NUMBER OF CLINICAL HOURS PER WEEK _____
NUMBER OF HOURS TEACHING IN CLINICAL SETTING PER WEEK _____
NUMBER OF HOURS PERFORMING ADMINISTRATIVE OVERSIGHT PER WEEK _____
NUMBER OF HOURS CLINICAL RESEARCH PER WEEK _____

SECTION C - LOCATIONS

PHYSICIAN IS WORKING AT THE FOLLOWING CLINICAL SITES:

1. _____
2. _____
3. _____
4. _____

SECTION D – Hours

INCREASE OR DECREASE HOURS PER WEEK: TOTAL CURRENT HOURS WORKED: _____ CHANGE TO: _____

CURRENT # CLINICAL HOURS PER WEEK: _____ CHANGE TO: _____

CURRENT # HOURS TEACHING IN CLINICAL SETTING PER WEEK: _____ CHANGE TO: _____

CURRENT # HOURS PERFORMING ADMINISTRATIVE DUTIES PER WEEK: _____ CHANGE TO: _____

CURRENT # HOURS PERFORMING CLINICAL RESEARCH PER WEEK: _____ CHANGE TO:_____

COMMENTS: _____

SECTION E – SIGNATURE

SEND CERTIFICATE OF INSURANCE TO: _____

SIGNATURE: _____ **DATE:** _____