The GW Medical Faculty Associates

# REQUEST FOR CERTIFICATE OF INSURANCE (COI)

Name of provider, including designation (please print):

_____

Dates of employment at MFA: _____
***If you are a resident, please indicate the dates of residency***

Department /Title: _____

Contact information:

Email: _____

Telephone: _____ Fax:_____

Address: _____

_____

_____

How do you wish to be contacted? ☐ Email ☐ Telephone ☐ Fax ☐ U.S. Mail
***If you choose email, please ensure that the email address provided above is valid***

**I acknowledge and understand that the COI reflects only the status of the policy when the COI is issued and is not a guarantee that the policy will remain active throughout the policy period specified.**

Signature of provider/requestor: _____

Date: _____

Please email this form to: MFA-Office of the General Counsel- Risk Management
insurance@mfa.gwu.edu

***For claims history request, please complete a claims history request form and attach any documents with the specific language containing the claims history question.***