



The GW Medical Faculty Associates

REQUEST FOR TAIL LETTER

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

Signature of provider/requestor: _____

Date: _____

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