

**Health Insurance Acknowledgement**

I hereby acknowledge that I currently possess and will maintain sufficient health insurance coverage, without lapse, throughout my enrollment in the Program, because infectious agents and environmental hazards are inherent risks during clinical education. I understand that sufficient health insurance coverage includes hospitalization and medication coverage. I understand that the Program is NOT responsible for monitoring the adequacy of my insurance coverage. As evidence of coverage, I will include a copy of my insurance identification card with this acknowledgement.

I understand that all healthcare expenses incurred during my enrollment in the PA Program are solely my responsibility and NOT the responsibility of University of Wisconsin-La Crosse or Gundersen, Mayo, or Marshfield Clinic Health Systems.

I understand that I must notify the Program of any change in my health insurance coverage within 30 days of change, and I will provide current proof of insurance.

**\*Attach a copy of your insurance identification card to this form. \***

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Student’s Signature Date

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Student’s Printed Name