

**CHICAGO STATE UNIVERSITY**  
**Master of Social Work Program**

**REQUEST FOR CERTIFICATE OF INSURANCE COVERAGE/PROOF OF LIABILITY INSURANCE**

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Placement Type: \_\_\_\_\_ Foundation \_\_\_\_\_ Advanced \_\_\_\_\_ School SW \_\_\_\_\_ Post MSW

Dates field placement will begin: \_\_\_\_\_

Date field placement will end: \_\_\_\_\_

Agency Name:

\_\_\_\_\_

Agency Address, City, State, Zip Code: