



**PROFESSIONAL INSURANCE
STATEMENT**

DIVISION OF SPECIALIZED CARE
FOR CHILDREN
2815 West Washington Street
Suite 300
P.O. Box 19481
Springfield, IL 62794-9481
Fax: (217) 793-0773
Toll Free: (877) 791-5170

STATEMENT CONCERNING PROFESSIONAL QUALIFICATIONS AND LIABILITY INSURANCE

I have reviewed the criteria used by the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC), to assess qualifications in my professional discipline. I affirm that my practice is covered by professional liability insurance in the amount of not less than \$1,000,000 per occurrence and an annual aggregate limit not less than \$3,000,000 (or the limits of liability set by law in any state other than Illinois in which I practice). I also maintain general (premises) liability insurance coverage of \$1,000,000 per incident. Additionally, I agree to maintain continuous coverage in the amount required by DSCC (or the state other than Illinois in which I practice) for the length of time I am a provider of services for DSCC clients. If my professional liability coverage is discontinued or reduced below the amounts noted above, I agree to purchase sufficient coverage to include the services provided to DSCC clients. My coverage includes an Extended Reporting Period (Tail Coverage). I recognize that DSCC retains the right to modify insurance requirements from time to time and will notify me of such changes.

By this endorsement, I affirm that I possess all licensure, certification, etc., required by my state for practice in my discipline and that my practice is covered by professional liability insurance which meets or exceeds the minimum amounts recommended for my discipline or set by law in the state(s) in which I practice.

Attached is proof of my professional and general liability insurance and tail coverage endorsement. I will send you updated proof when it is renewed. I recognize that failure of DSCC to obtain such proof of coverage shall not be deemed to be a waiver of the coverage requirement.

Name of Insurance Company_____

Policy Number_____

Policy Holder_____

Date

Signature

Name (print or type)

Do not include my practice name and information in the *Illinois Provider Directory for Children with Special Health Care Needs*: <http://www.illinoisproviderdirectory.org/icaap/>.