FORM 3 INTERNSHIP STATEMENT OF INSURANCE COVERAGE

The Board of Trustees of Western Illinois University on behalf of
The Department of Instructional Design & Technology

I, _____, certify that I have paid for the Student Health and (Student's Name)

Major Medical Program which is provided to Western Illinois University Students (or have voluntarily waived University Insurance by providing, verifying, and maintaining an equivalent policy through a private insurance representative) and that I will not cancel or change this insurance coverage during the period of my Internship.

I further represent that I am above the age of 21 years,* with full understanding of all risk involved and agree that this "Statement of Insurance" shall be binding upon my heirs, executors, administrators, and assignors.

_____

Student Signature

_____

Witness Signature

* For persons under the age of 21, parental signature required:

_____

Parental Signature