Student's Name: ______________________________
UH ID#: ______________________________
Program:______________________________

UNIVERSITY OF HAWAI'I • KAPI'OLANI COMMUNITY COLLEGE

Nursing Department

Exclusion of "WORKER'S COMPENSATION" Coverage
Confirmation of HEALTH INSURANCE Coverage

This notice is to inform you that should you sustain an injury or become ill while you are performing your duties as a student, medical coverage for such injury or illness will be at your expense. The State Law which covers Worker's Compensation specifically excludes "service...performed in a voluntary or unpaid capacity..." Since you are unpaid for your clinical time, you are excluded from any Worker's Compensation_coverage.

In case of illness or injury, it is required that you carry medical coverage throughout the duration of your nursing program. **Please attach a copy of your health insurance card to verify your health insurance coverage.**

In the event of illness or injury while you are performing your duties as a student, please report it to your instructor immediately.

This is to confirm that I acknowledge the above information regarding non-coverage of Worker's Compensation in the case of illness or accident while performing duties as a student and agree to maintain my health insurance coverage throughout the duration of my nursing program. I also agree to notify the Nursing Department of any change in my health insurance coverage.

SIGNATURE ___________________________________ DATE________________

PRINT NAME___________________________________