NOAA Form 57-03-07
(3-15)

U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

VERIFICATION OF LIABILITY COVERAGE

APPLICANT INFORMATION

CONTRACT DIVER NAME (Last, First MI)	NAME of EMPLOYER / CONTRACTOR		
WORK ADDRESS	CITY	STATE	ZIP
E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER	
NOAA LINE or STAFF OFFICE and UNIT ASSIGNED	DIVE OPERATIONS START DATE	DIVE OPERATIONS END DATE	

The information below verifies that the above named individual is covered for costs associated with any dive accident or other medical emergency that may occur during the course of his/her work at or with NOAA.

Instructions: Indicate below the type and extent of coverage, including, but not limited to; emergency transportation (e.g. MEDEVAC), hyperbaric treatments, other medical treatments, hospitalization, and compensation for lost wages associated with extended absence due to work-related medical emergencies (e.g. worker's compensation). Attach supporting information and documentation as necessary.

LIABILITY COVERAGE

TYPE and EXTENT of COVERAGE		POLICY START DATE	POLICY END DATE
INSURANCE COMPANY	PHONE NUMBER	POLICY NUMBER	

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COMMENTS

LIABILITY COVERAGE VERIFICATION

NAME and TITLE of COMPANY REPRESENTATIVE	COMPANY REPRESENTATIVE SIGNATURE	DATE

RESET