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| --- |
| **CERTIFICATE OF INSURANCE** |
| **PLEASE FILL OUT 1 FORM FOR EACH EVENT** |
|  |
| *NAME OF FACILITY Where the event is taking place* |
|  |
|  |
| *ADDRESS OF FACILITY Where the event is taking place* |
| *City:* |
| *State:* |
| *Zip:* |
|  |
|  |
| *CONTACT PERSON'S INFORMATION* Name of person to receive the certificate |
| *First:* |
| *Last:* |
| *Phone #:* |
| *E-mail address:* |
|  |
|  |
| IMPORTANT REQUIREMENT |
| *FAX NUMBER if no email address* |
|  |
|  |
| *DATE OF EVENT* |
| *Date:* |
|  |
| *TIMES FOR THE EVENT* |
| *Start and end times:* |
|  |
| *TYPE OF EVENT & NOTES* |
|  |
|  |
|  |