**REQUEST FOR CERTIFICATE**

Please TYPE OR PRINT with ballpoint pen.

LOCATION.. means the name of the actual Location of the dance. State complete address: street, city, state and zip code.

NAME OF THE ADDITIONAL INSURED... means the owner or organization of owners who wants their names added to your liability insurance. Normally this differs from the name of the facility being used or the location of that facility.

DATE [s] ... means special dance date. "Example: Every Sat. in 20xx is O.K."

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | LOCATION OF EVENT | | | | |  | | | | | | | | | | | | | | |
| STREET ADDRESS | | | | | |  | | | | | | | | | | | | | | |
| CITY | | | | | |  | | | | | | | | STATE |  | | | ZIP | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| 2. | NAME(S) OF ADDITIONAL INSURED | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | |
| STREET ADDRESS | | | | | |  | | | | | | | | | | | | | | |
| CITY | | | | | |  | | | | | | | | STATE |  | | | ZIP | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| 3. | LIST OF ALL BUILDINGS USED | | | | | | |  | | | | | | | | | | | | |
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| 4. | DATE(S) AND TIME OF EVENT | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 5. | TYPE OF EVENT | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Requested by | | | Federation/Organization | | | |  | | | | | | | | | | | | Date |  |
| Requested by | | | **Club** | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Person making request | | | | |  | | | | | | | | | | | | | | | |
| Street Address | | | |  | | | | | | | | | | | | | | | | |
| City | |  | | | | | | | | State | | |  | | | Zip |  | | | |
| Phone | |  | | | | | | | | | | **Email** | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Send to: Federation /Association Insurance Chairman: | | | | | | | | | | |  | | | | | | | | | |
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