

Chabot-Las Positas Community College District

Request For Certificate of Insurance

Name: Chad McMullen Dept: Public Safety

Certificate Holder (i.e. The agency requesting the Certificate of Insurance.)
Name: OAK VALLEY HOSPITAL DISTRICT
Address: 350 SOUTH OAK AVENUE
OAKDALE, Ca. 95361
Attn: _____

Description of Operations
PARAMEDICAL INTERNSHIPS - CLINICAL HOSPITAL SETTINGS

Is This a Special Event? (i.e. Is this off campus event a one time thing?)
Yes No
Event Dates & Time: _____
Location: _____
Sponsor: _____
Participants: _____
Details of Event: _____
Special Requirements: _____

Additional Insured/Additional Covered Party?* Yes No
(i.e. Is the requesting Agency asking to be an additional insured?)
*If requesting Additional Insured/Additional Covered Party, please forward a copy of the contract or agreement along with the request.

Comments:
COVERAGE REQUIRED FOR INTERNSHIPS

Send To:
Name: CHIEF EXECUTIVE OFFICER
Address: 350 SOUTH OAK AVENUE
OAKDALE, Ca. 95361
Attn: _____