



INSURED NAME: _____

REQUEST RECEIVED FROM: _____

DATE: _____ TIME: _____

CERTIFICATE TO: _____

Address: _____

City, State, Zip _____

FAX NUMBER: _____

ATTENTION: _____

JOB DESCRIPTION/DURATION: _____

SPECIAL REQUIREMENTS: (OR ATTACH A COPY OF THE CONTRACT REQUIREMENTS)

Additional Insured? _____

Limits of Liability? _____

Mail to: **Leonard Adams Company**
5201 SW Westgate Dr, Suite 300
Portland, OR 97221

FAX to: 503.296.0044

ATTN: _____