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| **Chapter / Area Team Name:** | Click or tap here to enter text. |  |
| **Chapter / Area Team ID#:** | Click or tap here to enter text. |  |

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| **Activity Person in Charge (if applicable):** |
| |  |  |  | | --- | --- | --- | | Name: |  | Click or tap here to enter text. | | Phone: |  | Click or tap here to enter text. | | Email: |  | Click or tap here to enter text. | | Date of Activity: | | Click or tap here to enter text. | | Place of Activity: | | Click or tap here to enter text. |   **Party Requesting Certificate of Insurance (Certificate Holder):**   |  |  |  | | --- | --- | --- | | Name: |  | Click or tap here to enter text. | | Address: |  | Click or tap here to enter text. | |  |  | Click or tap here to enter text. | | Attention: | | Click or tap here to enter text. | | Phone: | | Click or tap here to enter text. | | Fax/Email: | | Click or tap here to enter text. | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | |  | | **Description of Operations or Activities:** | | | Click or tap here to enter text. | | | | | | | | | | | | |  | |  |  | | | | | |  |  |  |  |  |  | | **Additional Requirements by Party Requesting Certificate of Insurance:** | | | | | | | | | | |  |  |  |  | |  | |  | Click or tap here to enter text. | | | | | | | | | | | | |  | |  | Click or tap here to enter text. | | | | | | | | | | | | |  | |  | Click or tap here to enter text. | | | | | | | | | | | | |  | |  |  | | | | | |  |  |  |  |  |  | | **Signature:** | |  | Click or tap here to enter text. | | | | | | | | | | | | | **Date:** | |  | Click or tap to enter a date. | | | | | | | | | | | | |  | |  |  | | | | | |  |  |  |  |  |  | | **Please fax, mail or e-mail the complete form, in *WORD format,* to:** | | | |  |  |  |  | |  |  | **AFS-USA, Inc**.  *Attn: Field Finance* | | | | | | |  |  | 120 Wall Street Suite 1600 | | | | | | |  |  | New York, NY 10005 | | | | | | |  |  | Fax: (646) 937-6033 | | | | | | |  |  | Email: [fieldfinance@afsusa.org](mailto:fieldfinance@afsusa.org) | | | | | | |