REQUEST FOR SDP CERTIFICATE OF INSURANCE
To Be Completed By Department or Program Requesting a Certificate of Insurance

Date of Request ________________

SDP Contact Information
SDP Contact Name (First & Last) ____________________________________________
SDP Contact Phone _______________________________________________________
SDP Contact Email Address ________________________________________________

Vendor Contact Information
Vendor Contact Name (First & Last) _________________________________________
Vendor Name & Business Address (Street, City, Zip) ____________________________
Vendor Contact Phone _____________________________________________________
Vendor Contact Email Address ______________________________________________

Details of Activity
Name of School (ES, MS, HS) requesting Certificate of Insurance ________________
Specific Address of activity (if different from vendor address) ___________________
________________________________________________________________________

Date(s) of activity __________________________________________________________
Time(s) of activity (include set up/break down of activity) _______________________
________________________________________________________________________
Specific Activities that will be occurring _______________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Location of the activity (Must include room # or other specific info if less than the entire facility used).
________________________________________________________________________

Will the facility be used by any other person/entity during the time the SDP will be using the facility or performing the activity (Circle Yes or No) _____________________________

Has the activity and location received approval by all necessary reviews (Circle Yes or No) _____________________________