ADVANTAGE PERSONNEL RESOURCES

WORKER'S COMPENSATION INSURANCE CERTIFICATE REQUEST FORM

Client Company Information:

Company Name:_____

Company Fax #: _____ Company Phone #: _____

Requested By: _____ Date Requested: _____

Certificate Holder Information:

Certificate Holder Name: _____

Address: _____

City:_____ State: _____ ZIP: _____

Attention: _____

Fax #: _____ Phone #: _____

Complete address and fax number are required to issue certificate.

Job Site Location:

Project Name: _____

Address: _____

City:_____ State: _____ Zip: _____

PLEASE COMPLETE THIS CERTIFICATE REQUEST FORM AND

Fax to: 866-203-0907 or Email to: certificates@apradvantage.com

Please allow up to 24 hours to process your request.