



This is to certify that the insured named below is insured as described below.

This form must be completed and signed by your insurer or insurance broker.

- Note:**
1. Proof of liability Insurance will be accepted on this form only (with no amendments).
 2. If a facsimile has been transmitted, the original certificate must follow.
 3. Insurance company must be licensed to operate in Canada.

Name of Insured	Telephone Number (including area code)	Fax Number (including area code)
Insured's Address (Apartment/Suite Number, Street Number, Street Name, City, Province, Postal Code)		

Type of Insurance	Insurance Company (Full Legal Name)	Policy Number	Effective Date Year/Month/Day	Expiry Date Year/Month/Day	Limits of Liability (Bodily Injury & Property Damage Inclusive)
Commercial General Liability					\$
<input type="checkbox"/> Umbrella <input type="checkbox"/> Excess					\$
<input type="checkbox"/> Other (Explain)					\$

Commercial General Liability: Occurrence Basis, Including Personal Injury, Property Damage, Broad Form Property Damage, Contractual Liability, Non-Owned Automobile Liability, Owner's and Contractor's Protective Coverage, Products - Completed Operations, Contingent Employers Liability, Cross Liability Clause and Severability of Interest Clause.

Tenant's Legal Liability: NO or YES (Limit) \$ _____

MOTOR VEHICLE LIABILITY					\$
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Motor Vehicle Liability - must cover all vehicles owned, or operated by, or on behalf of the Insured.

This is to certify that the Policies of Insurance as described above have been issued by the undersigned to the Insured named above and are in force at this time.

If cancelled or changed in any manner, that would affect WGH as outlined in coverage specified herein for any reason, so as to affect this certificate, thirty (30) days prior written notice by registered mail or facsimile transmission will be given by the insurer(s) to:

Woodstock General Hospital
 310 Julianna Drive
 Woodstock, Ontario N4V 0A4
 Phone: (519) 421-4270
 Fax: (519) 537-5142

This certificate is executed and issued to the aforesaid **Woodstock General Hospital** on the day and date herein written below.

Name of Insurance Company or Broker (completing form)	Telephone Number (including area code)
Address (Apartment/Suite Number, Street Number, Street Name, City, Province, Postal Code)	Fax Number (including area code)
Name of Authorized representative or Official and Position (<i>Please type or print</i>)	Signature of Authorized Representative or Official
	Date (Year/Month/Day)