

**FLORIDA FARM LABOR REGISTRATION AND TESTING
WORKERS' COMPENSATION INFORMATION**
(Workers' Compensation Coverage Carried By Contractor Listed Below)

Name of Contractor/Corporation

Social Security or License Number

Insurance Company Name

Local Insurance Representative

Home Office Address

Office Address

City, State and Zip Code

City, State and Zip Code

(_____)_____
Telephone Number

(_____)_____
Telephone Number

Workers' Compensation Policy Number

Effective: _____
From To

TO BE COMPLETED BY THE INSURANCE CARRIER OR CARRIER'S DULY AUTHORIZED AGENT

I HEREBY CERTIFY THAT THE ABOVE POLICY IS IN EFFECT, HAS BEEN ISSUED TO THE ABOVE NAMED APPLICANT, AND THAT THE POLICY COVERS THE TRANSPORTATION OF WORKERS.

Signature of Insurance Representative

Date