

PALM BEACH COUNTY
 BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: November 19, 2013 Consent [] Regular
 [] Ordinance [] Public Hearing

Department
 Submitted By: Community Services
 Submitted For: Division of Senior Services (DOSS)


I. EXECUTIVE BRIEF


Motion and Title: Staff recommends motion to approve: Non-Financial Agreement No. 2013-015 with Workforce Alliance, Inc., to provide work experience and training activities for Workforce Alliance, Inc. Program participants at DOSS work sites effective November 19, 2013.

Summary: This agreement will allow Workforce Alliance, Inc. to place program participants at DOSS work sites for the provisions of work experience and training activities. No County funds are required. (DOSS) Countywide (TKF)

Background and Justification: This agreement will facilitate the utilization of Workforce Alliance, Inc. program participants for a job training experience. The participants do not displace regular employees, but work with employees under close supervision to increase their employability skills for eventual placement into unsubsidized paid employment leading to economic self-sufficiency for the individual. As a result of the agreement the County will use these volunteers to provide general clerical office duties.

Attachments: Non-Financial Agreement with Workforce Alliance, Inc.

Recommended By:  10/25/13
 Department Director Date

Approved By:  11-12-13
 Assistant County Administrator Date

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2014	2015	2016	2017	2018
Capital Expenditures					
Operating Costs					
External Revenue					
Program Income					
In-Kind Match (County)					
NET FISCAL IMPACT	0				

# ADDITIONAL FTE POSITIONS (Cumulative)					
-----------------------------------------	--	--	--	--	--

Is Item Included In Current Budget? Yes _____ No _____

Budget Account No.:

Fund _____ Dept _____ Unit _____ Object _____ Program Code _____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

There is no fiscal impact associated with this item.

C. Departmental Fiscal Review:

M

 Taruna Malhotra, Director, Financial & Support Svcs.

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Development and Control Comments:

Lusan Theary 11/6/13

 OFMB K/D
 11/6
 cc 11/6/13

Dr. J. Jacobson 11/12/13

 Contract Development and Control

B. Legal Sufficiency:

LJR 11/12/13

 Chief Assistant County Attorney

C. Other Department Review:

 Department Director

This summary is not to be used as a basis for payment.

COMMUNITY SERVICE & WORK EXPERIENCE PROGRAM
NON-FINANCIAL AGREEMENT NUMBER 2013-015
BY AND BETWEEN
WORKFORCE ALLIANCE, INC.
1951 North Military Trail, Suite D, West Palm Beach, Florida 33409
AND
PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS
(INSERT PROVIDER NAME)

PROVIDER FEI #: 59-6000785

PROVIDER ADDRESS: 810 DATURA STREET, ROOM 300, WPB, 33401

PROVIDER DESCRIPTION: PROVIDE QUALITY SERVICES TO SENIORS

WHEREAS, Workforce Alliance, Inc. (hereinafter "Alliance") wishes to place Alliance Program participants with the Provider for the provisions of work experience and training activities; and

WHEREAS, the Provider wishes to provide work experience and training activities for Alliance Program participants (hereinafter "participants");

NOW THEREFORE, the parties enter into this Agreement for the provision of work experience and training activities work site services upon the following terms and conditions:

I. Term

This Work Experience Program Non-Financial Agreement ("Agreement") shall begin on the date last signed by both parties. This Agreement shall be automatically renewed annually without action of any party, unless earlier terminated pursuant to Article VII. of this Agreement or a participant has not completed his/her work experience with the Provider, in which event this Agreement shall continue to be in full force and in effect until the duration of the remaining time required for the participant to complete his/her work experience with the Provider.

II. Participant Status

The participant is not an employee of the Provider or Alliance.

III. Independent Contractor

Both parties in the performance of this Agreement will be acting in an individual capacity and not as agents, employees, partners, joint venturers, or associates of one another.

IV. Provider Representations and Duties

1. Provider represents that:

It is a private non-profit or public non-profit corporation, or local governmental entity.

It is a private for-profit or public for-profit entity licensed to do business in the State of Florida.

and is capable of providing a work experience to Alliance participants in accordance with the terms of this Agreement.

2. Provider agrees to:

A. develop and provide a work site designed to provide participants with a non-paid, job training experience commonly referred to as a "Work Experience".

B. maintain the confidentiality of all information provided by or about any participant, except as otherwise approved and authorized in writing by the participant, or as otherwise authorized by law.

- C. provide participants with a work experience described in "Attachment A Work Site Training Outline/Job Description" and attached hereto.
- D. provide work experience training to participants so he/she can adequately perform his/her work experience. Work experience hours shall not exceed the maximum hours per month stated on the participant's referral.
- E. provide participants with the same working hours, lunch periods and break times that would be afforded to paid employees.
- F. not to place participants in positions that are involved in political activity or the instruction of worship and not to engage participants in sectarian activities or in the construction of sectarian facilities. Participants may not engage in the operation or maintenance of any facility used or to be used for sectarian activity.
- G. notify Alliance in writing immediately upon notice of the status of a participant when one or more of the following situations occur:
 - a) the participant has failed to attend the initial interview or refused a suitable work site offer or voluntarily quit training.
 - b) the participant was not accepted by the Provider into a work experience.
 - c) the participant has experienced absenteeism or sickness or other problems.
 - d) the participant secured employment with the Provider or with another entity.
- H. comply with all applicable federal, state and local laws, regulations, policies and procedures relative to Alliance's work experience program.
- I. obtain written approval from Alliance before assigning this Agreement.
- J. complete and maintain the required participant time record forms, referral, progress reports and periodic evaluation forms and provide such records upon request by Alliance for monitoring purposes.

V. Alliance Representations and Duties

- 1. Alliance agrees to:
 - A. provide a written referral to the Provider for consideration in a work experience with the Provider containing the participant's name, date of referral and the Program in which the participant is a recipient.
 - B. provide supportive services, subject to funding availability, to eligible participants that enable the participant to maintain his/her work experience activities and that are allowed by the Program rules, laws and regulations.
 - C. inform the Provider of the maximum number of hours each participant is required to participate and the expected length of the participant's placement in the work site activity.
 - D. provide the required participant time-record forms, progress reports and periodic evaluation forms to be completed by the Provider.
 - E. complete "Attachment C Work Site Letter Transmittal".

VI. Manner of Service Provision

- 1. The work site Work Site Training Outline/Job Description ("Attachment A") must be approved by Alliance prior to the work experience beginning for any participant.
- 2. Provider agrees to provide the necessary instruction, supervision and equipment for a participant to perform work experience duties.

3. Provider agrees to submit to Alliance on a weekly basis a work experience training program time sheet signed and dated by Provider and the participant. The employee(s) noted by Provider on "Attachment B Authorizing Signature Page" of this Agreement will be responsible for signing the participant's time sheet. Only those Provider employee(s) noted on "Attachment B Authorizing Signature Page" and the Alliance Community Service & Work experience referral issued by Alliance will be authorized to sign the participant's time sheet.
4. Provider shall train the participant with the necessary skills for an entry level work experience in the designated job title.
5. No participant may participate in a Provider work experience unless the participant is referred to Provider by Alliance in writing and in accordance with the terms of this Agreement.
6. All participants are to be provided with the same working conditions by Provider accorded to other employees presently in the Provider's work force. However, for purposes of workers' compensation coverage the participant will be considered an employee of the State of Florida. Participants shall not be considered employees of Provider, although Provider shall have all supervisory responsibility.
7. No currently employed Provider employee shall be displaced by a participant. This includes partial displacement such as reduction in the hours of non-overtime work, wages or employment benefits. It is illegal for a Provider to displace any regular employee or fail to fill a vacancy so that a worksite participant may fill the job requirements. Based upon the above, Provider must ensure that employees of Providers organization are notified of the Work Experience Program displacement rules and his/her rights under the law and ability to file a grievance. Provider's execution of the Work Experience Program Non-Financial Agreement is with the expectation that Provider will be monitored by Alliance for compliance with this provision and Providers that violate this provision of the Agreement and requirement of the law will be terminated from participation in the program.
8. No participant shall be hired into or remain working in any position when the same or substantially equivalent position is vacant due to a hiring freeze or when any regular employee is on lay-off from the same or substantially equivalent position or when the regular employee has been bumped and has recall or bumping rights to that position pursuant to the provider's personnel policy or collective bargaining agreement.
9. Provider may conduct background checks of potential participants as necessary and as a pre-requisite for acceptance of any participant at a work site.

VII. Termination

Either party may terminate this Agreement, with or without cause, at any time by giving written notice five days in advance to the other party. This Agreement will be modified at anytime without notice to the other party upon change or amendment to any law or regulation that governs the Program.

VIII. Notice and Contact

The name, address and telephone number of each parties representative to this Agreement is as follows:

Alliance

President/CEO
 Workforce Alliance, Inc.
 1951 North Military Trail, Suite D
 West Palm Beach, Florida 33409
 Telephone (561) 340-1060 Ext. 2221

Provider

Point of Contact Name: Palm Beach County Division of Senior Services
 Address: 810 Datura Street, Room 300, WPB, FL 33401
 Telephone: Dorothy Little (561) 355-4683
 E-Mail: Dlittle@pbcgov.org

In the event a different representative is designated by either Party after execution of this Agreement, written notice including the name, address and telephone number of the new representative will be sent in writing to the other Party.

IX. Monitoring

At any time and as often as Alliance, the State of Florida, United States Department of Labor, Comptroller General of the United States, the Inspector General of the United States and the State of Florida, or their designated agency or representative may deem necessary, Provider shall make available all appropriate personnel for interviews and all participant records or other data relating to matters covered by this Agreement for the purpose of monitoring activities and determining compliance with all applicable rules and regulations, and the provisions of this Agreement. Provider shall respond in writing to monitoring reports and requests for corrective action plans within 20 working days after the receipt of such request from Alliance.

X. Indemnification

To the extent permitted by applicable law including Federal law and regulation as currently reflected in OMB Circular A-122, Attachment B, subsections 10 and 22, Alliance shall protect, defend, reimburse, indemnify and hold Provider, its agents, employees and elected officers harmless from and against all claims, liability, expense, loss, cost, damages or causes of action of every kind or character, including attorney's fees and costs, whether at trial or appellate levels or otherwise, arising during and as a result of their performance of the terms of this Agreement or due to the acts or omissions of Alliance.

XI. Insurance

Alliance shall, at its sole expense, agree to maintain in full force and effect at all times during the life of this Contract, insurance coverages and limits (including endorsements), as described herein to the extent permitted by Federal law and regulation, currently found in OBM Circular A-122 Attachment B subsection 22 (the "Federal Limitation"). Alliance shall agree to provide the Provider with at least ten (10) day prior notice of any cancellation, non-renewal or material change to the insurance coverages. The requirements contained herein, as well as Provider's review or acceptance of insurance maintained by Alliance are not intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by Alliance under the Agreement.

XII. Entire Agreement

This Agreement constitutes the entire understanding of the parties with respect to the subject matter hereof. All other prior agreements, understandings and representations regarding the subject matter hereof are hereby superseded and terminated.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK]

By signing this Agreement, I represent to the other party that I have the legal authority to sign this Agreement. Further, by signing this Agreement, I acknowledge, agree, and represent to the other party that I have the legal authority to bind my agency, business, or legal entity, including its officers, boards, employees, staff, to perform the duties, responsibilities, and other obligations set forth in this Agreement and any attachment thereto.

APPROVED BY Workforce Alliance, Inc. (Alliance)

By: Steve Craig
Signed Alliance, Steve Craig President/CEO

WITNESS: Mary Butler

DATE 10-14-13

PROVIDER: PALM BEACH COUNTY, FLORIDA,
A Political Subdivision of the State of
Florida

SIGNED
BY: _____
Chair ~~XXXXXX~~

DATE: _____

SHARON R. BOCK, Clerk and Comptroller

BY: _____

DATE: _____

FEDERAL ID NUMBER: 59-6000785

FISCAL YEAR END DATE: _____

Approved as to form and legal sufficiency

Chief Assistant County Attorney

Approved as to terms and conditions

[Signature]
Department Director

ATTACHMENT A - 1
WORK SITE TRAINING OUTLINE/JOB DESCRIPTION

Indicate below the location, job title(s), days, hours and number of slots available at the work-site. If there is more than one job title available at the work-site in the same location, please list the job duties separately. Many providers have different positions available at different locations, if this is the case; please complete a separate Work Site Training Outline/Job Description. Thank you!

1. **Work Site Name and Location:** Enter the legal address of the work site where the participant will be located.

West County Senior Center - 2916 State Road 15, Belle Glade, FL

Worksite Business Status: [check one] Nonprofit or Public Organization For Profit

2. Contact Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____
 Alternate Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____

Job Title	1. <i>Staff Assistant / Aide</i>	2.	3.	4.
Work Days	S M T W TH F S <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Work Hours	<i>up to 35 hrs/week</i>			
# of Slots Available				

3. **Work Site Duties:** List the specific job duties at the work site the participant will perform for each job title listed above

Job Title #1 Job Duties:
See attached Mastery Skills list.

Job Title #2 Job Duties:

Job Title #3 Job Duties:

4. List any pre-requisites for acceptance of a participant (finger printing, background check, interview, testing, etc) for the work site activity.

Interview

WORK SITE TRAINING OUTLINE/JOB DESCRIPTION

Indicate below the location, job title(s), days, hours and number of slots available at the work-site. If there is more than one job title available at the work-site in the same location, please list the job duties separately. Many providers have different positions available at different locations, if this is the case; please complete a separate Work Site Training Outline/Job Description. Thank you!

1. **Work Site Name and Location:** Enter the legal address of the work site where the participant will be located.

North County Senior Center, 5217 Northlake Blvd., P. B. Gardens, FL

Worksite Business Status: [check one] Nonprofit or Public Organization For Profit

2. Contact Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____
 Alternate Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____

Job Title	1. <u>Staff Assistant / Aide</u>	2.	3.	4.
Work Days	S M T W TH F S <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Work Hours	<u>Up to 35 hrs /wk</u>			
# of Slots Available				

3. **Work Site Duties:** List the specific job duties at the work site the participant will perform for each job title listed above

Job Title #1 Job Duties:
see attached Mastery Skills list.

Job Title #2 Job Duties:

Job Title #3 Job Duties:

4. List any pre-requisites for acceptance of a participant (finger printing, background check, interview, testing, etc) for the work site activity.

Interview

WORK SITE TRAINING OUTLINE/JOB DESCRIPTION

Indicate below the location, job title(s), days, hours and number of slots available at the work-site. If there is more than one job title available at the work-site in the same location, please list the job duties separately. Many providers have different positions available at different locations, if this is the case; please complete a separate Work Site Training Outline/Job Description. Thank you!

1. **Work Site Name and Location:** Enter the legal address of the work site where the participant will be located.

Mid County Senior Center, 3680 Lake Worth Rd., Lake Worth, FL

Worksite Business Status: [check one] Nonprofit or Public Organization For Profit

2. Contact Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____
 Alternate Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____

Job Title	1. Staff Assistant / Aide	2.	3.	4.
Work Days	S M T W TH F S <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	S M T W TH F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Work Hours	up to 35 hrs /wk			
# of Slots Available				

3. **Work Site Duties:** List the specific job duties at the work site the participant will perform for each job title listed above

Job Title #1 Job Duties:
see attached Mastery Skills list.

Job Title #2 Job Duties:

Job Title #3 Job Duties:

4. List any pre-requisites for acceptance of a participant (finger printing, background check, interview, testing, etc) for the work site activity.

Interview

**ATTACHMENT B - 1
AUTHORIZING SIGNATURE PAGE**

Please include the names of all those persons in your organization that would be responsible for signing all timesheets submitted to Alliance. This will help Alliance ensure that those signing the timesheets are valid and accurate. Alliance appreciates your assistance!

PROVIDER STAFF NAME (PRINT)	STAFF SIGNATURE
Faith Manfra	<i>Faith Manfra</i>
Dorothy Little	<i>Dorothy Little</i>
Alnita Coleman	<i>Alnita Coleman</i>
Hugo Montenegro	<i>Hugo Montenegro</i>
Patty Jordan	<i>Patty Jordan</i>
Debbie Blake	<i>DBlake</i>
Antoinette Austin	<i>A. Austin</i>
Joseph Horvath	<i>Joseph Horvath</i>
Keith Babb	<i>Keith Babb</i>

**ATTACHMENT C
WORK SITE LETTER OF TRANSMITTAL**

Attached please find a Work Site Agreement that requires your approval. Please review the Agreement. Upon your approval sign your name and date below and forward the Agreement to the next individual listed on this transmittal page.

1. PERSON INITIATING THE AGREEMENT

Patrick Cannon 10-14-13
Name Date

2. ALLIANCE WTP PROGRAM DIRECTOR

Amara Price 10/16/13
Name Date

3. ALLIANCE CONTRACTS DEPARTMENT
ATTN: Contracts Manager
1951 North Military Trail, Suite D
West Palm Beach, Florida 33409



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
6/26/2013

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Wells Fargo Insurance Services USA Inc 2054 Vista Parkway, Suite 400 West Palm Beach FL 33411-2718	CONTACT NAME: Clark Weimer PHONE (A/C, No, Ext): E-MAIL ADDRESS:	FAX (A/C, No):	
	INSURER(S) AFFORDING COVERAGE		NAIC #
INSURED Workforce Alliance, Inc. 1951 N. Military Trail Ste. D West Palm Beach FL 33409	INSURER A: Philadelphia Indemnity Ins Co.		
	INSURER B: Owners Insurance Company		
	INSURER C: Employers Assurance Company		
	INSURER D: Continental Casualty Ins. Co.		25402
	INSURER E:		
INSURER F:			

COVERAGES **CERTIFICATE NUMBER:** Cert ID 400087 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			PHPK956368	12/30/2012	12/30/2013	EACH OCCURRENCE \$ 1,000,000	
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000	
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person) \$ 5,000	
	GEN'L AGGREGATE LIMIT APPLIES PER:							PERSONAL & ADV INJURY \$ 1,000,000
	<input type="checkbox"/> POLICY	<input type="checkbox"/> PRO-JECT	<input type="checkbox"/> LOC					GENERAL AGGREGATE \$ 2,000,000
								PRODUCTS - COMP/OP AGG \$ 2,000,000
								\$
B	AUTOMOBILE LIABILITY			4871432900	2/14/2013	2/14/2014	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000	
	<input checked="" type="checkbox"/> ANY AUTO ALL OWNED AUTOS	<input type="checkbox"/> SCHEDULED AUTOS	<input type="checkbox"/> NON-OWNED AUTOS				BODILY INJURY (Per person) \$	
	<input checked="" type="checkbox"/> HIRED AUTOS	<input checked="" type="checkbox"/> SCHEDULED AUTOS	<input checked="" type="checkbox"/> NON-OWNED AUTOS				BODILY INJURY (Per accident) \$	
							PROPERTY DAMAGE (Per accident) \$	
							\$	
D	<input checked="" type="checkbox"/> UMBRELLA LIAB	<input type="checkbox"/> OCCUR		L4031235395	12/30/2012	12/30/2013	EACH OCCURRENCE \$ 7,000,000	
	<input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE					AGGREGATE \$ 7,000,000	
	<input type="checkbox"/> DED	<input checked="" type="checkbox"/> RETENTION \$ 10,000					\$	
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WCV702513315	7/1/2013	7/1/2014	WC STATU-TORY LIMITS	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y/N	N/A				E.L. EACH ACCIDENT \$ 500,000	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE \$ 500,000	
							E.L. DISEASE - POLICY LIMIT \$ 500,000	
							\$	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
 10 day notice of cancellation applies for non payment of premium Palm Beach County Board of County Commissioners, a political subdivision of the State of Florida, it's officers, employees, and agents
 c/o Palm Beach County Department of Airports, are named as additional insured with respect to general liability, and excess liability. Waiver of subrogation applies in favor of certificate holder. Re: lease of 3200 Belvedere Road, Bldg. 1169, West Palm Beach, FL. 33406

CERTIFICATE HOLDER Palm Beach County Board of County Commissioners a Political Subdivision of the State of Florida c/o Palm Beach County Dept. of Airports 846 PBIA West Palm Beach FL 33406	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE <i>Nola Black</i>

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