



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
06/04/2010

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 GAVIN INSURANCE AGENCY 2100 WEST 2ND AVENUE INDIANOLA IA 50125 | CONTACT NAME: MERRIE ROMINGER | | |
| | PHONE (A/C, No. Ext): 515-961-3377 | FAX (A/C, No): 515-961-3194 | |
| | E-MAIL ADDRESS: GAVININSURANCE@MCHSI.COM | | |
| | PRODUCER CUSTOMER ID #: 104101 | | |
| INSURED MY THERAPY COMPANY LLC. NPA MICHAEL MCBURNIE P.O. BOX 936 909 N. "B" STREET FAIRFIELD IA 52556 | INSURER(S) AFFORDING COVERAGE | | NAIC # |
| | INSURER A : ALLIED INSURANCE GROUP | | |
| | INSURER B : | | |
| | INSURER C : | | |
| | INSURER D : | | |
| | INSURER E : | | |
| | INSURER F : | | |

COVERAGES

CERTIFICATE NUMBER:

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 | | | ACPGLO7123281714 | 03/01/2010 | 03/01/2011 | 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 |
| | | | | | | | PERSONAL & ADV INJURY | \$ 1,000,000 |
| | | | | | | | GENERAL AGGREGATE | \$ 2,000,000 |
| | | | | | | | PRODUCTS - COMP/OP AGG | \$ 2,000,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | | |
| | <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC | | | | | | | |
| | AUTOMOBILE LIABILITY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | \$ |
| | <input type="checkbox"/> ANY AUTO | | | | | | BODILY INJURY (Per person) | \$ |
| | <input type="checkbox"/> ALL OWNED AUTOS | | | | | | BODILY INJURY (Per accident) | \$ |
| | <input type="checkbox"/> SCHEDULED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | \$ |
| | <input type="checkbox"/> HIRED AUTOS | | | | | | | \$ |
| | <input type="checkbox"/> NON-OWNED AUTOS | | | | | | | \$ |
| | UMBRELLA LIAB | <input type="checkbox"/> OCCUR | | | | | EACH OCCURRENCE | \$ |
| | EXCESS LIAB | <input type="checkbox"/> CLAIMS-MADE | | | | | AGGREGATE | \$ |
| | <input type="checkbox"/> DEDUCTIBLE | | | | | | | \$ |
| | <input type="checkbox"/> RETENTION \$ | | | | | | | \$ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | | | <input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) | <input type="checkbox"/> Y / <input checked="" type="checkbox"/> N | N / A | | | | E.L. EACH ACCIDENT | \$ |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - EA EMPLOYEE | \$ |
| | | | | | | | E.L. DISEASE - POLICY LIMIT | \$ |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATEHOLDER IS INCLUDED AS ADDITIONAL INSURED.

CERTIFICATE HOLDER

CANCELLATION

| | |
|---|--|
| MT. DIABLO UNIFIED SCHOOL DISTRICT 1936 CARLOTTA DRIVE CONCORD CA 94519 | 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 Merrie Rominger <small>Digitally signed by Merrie Rominger DN: cn=Merrie Rominger, c=US, o=Gavin Insurance Agency, email=merromi@mchsi.com Date: 2010.06.04 13:39:18 -05'00'</small> |

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ADDITIONAL REMARKS SCHEDULE

| | | |
|----------------------------------|-----------|--|
| AGENCY GAVIN INSURANCE AGENCY | | NAMED INSURED MY THERAPY COMPANY LLC. NPA |
| POLICY NUMBER | | |
| CARRIER | NAIC CODE | EFFECTIVE DATE: |

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
 FORM NUMBER: ACORD25 FORM TITLE: Certificate of Liability Insurance Old Format

CERTIFICATEHOLDER IS INCLUDED AS ADDITIONAL INSURED.