

Employee Drivers Form

Name

_____ (First) (Middle) (Last)

Street Address

City, State and Zip Code _____

Driver Licenses

State	License No	Type	Expiration Date

Accident Record For Past 3 Years. (Attach Sheet if More Space Is Needed)

Dates	Nature of Accident (head-on, rear-end, etc.)	Fatalities	Injuries
Last Accident _____			
Next Previous _____			
Next Previous _____			

Traffic Convictions And Forfeitures For The Past 3 Years (Other Than Parking Violations)

Location (City & State)	Date	Charge	Penalty

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES _____ NO _____

B. Has any license, permit or privilege ever been suspended or revoked? YES _____ NO _____

Physical History

List Any Physical Limitations (Such as Eyesight, Limb Impairment, Diabetes, Hearing) _____

Use Corrective Lenses? _____ Use Hearing Aid? _____

Date of Last Physical Examination _____ Doctor's Name and Address _____

TO BE READ AND SIGNED BY EMPLOYEE

It is agreed and understood that any misrepresentation of information given above shall be considered an act of dishonesty.

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

Date

Signature