

**APPLICATION FOR TAXICAB DRIVER AUTHORIZATION  
CITY OF SANDPOINT**

TAXICAB BUSINESS NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

BUSINESS TELEPHONE: \_\_\_\_\_

**If more than one driver, each must complete application form.**

NAME OF DRIVER: \_\_\_\_\_

DRIVER'S ADDRESS: \_\_\_\_\_

DRIVER'S HOME PHONE: \_\_\_\_\_

CELL PHONE NUMBERS: \_\_\_\_\_

AFTER HOURS CONTACT PHONE NUMBER: \_\_\_\_\_

NAME OF AFTER HOURS CONTACT: \_\_\_\_\_

DOB: \_\_\_\_\_ SS #: \_\_\_\_\_

DRIVERS LICENSE NUMBER AND STATE \_\_\_\_\_

U.S. CITIZEN: \_\_\_\_\_ YES \_\_\_\_\_ NO

HAVE YOU EVER BEEN ARRESTED: \_\_\_\_\_ YES \_\_\_\_\_ NO

***IF YES, PLEASE EXPLAIN ON THE BACK OF THIS FORM OR ON ATTACHED PAGES THE CIRCUMSTANCES AND DATES OF EACH ARREST, IF MORE THAN ONE.***

**MEDICAL CERTIFICATION: *YOU ARE REQUIRED TO SUBMIT, AT THE TIME OF APPLICATION OR RENEWAL, A CURRENT MEDICAL EXAMINER'S CERTIFICATE SIGNED BY YOUR PHYSICIAN. SEE ATTACHED.***

**IN SUBMITTING THIS APPLICATION, I HEREBY AUTHORIZE THE CHIEF OF POLICE OR HIS DESIGNATED AGENT TO CONDUCT AN INVESTIGATION TO DETERMINE THE VALIDITY AND COMPLETENESS OF THE INFORMATION I HAVE PRESENTED ON THIS APPLICATION, INCLUDING, BUT NOT LIMITED TO, NATIONAL LAW ENFORCEMENT AGENCIES. THE ANNUAL \$60 BACKGROUND CHECK FEE IS SUBMITTED HEREWITH.**

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE FEE PAID \_\_\_\_\_ CASH \_\_\_\_\_ CHECK # \_\_\_\_\_ RECEIPT # \_\_\_\_\_

APPROVED: \_\_\_\_\_ YES \_\_\_\_\_ NO

SIGNATURE - CHIEF OF POLICE: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICAL EXAMINER'S CERTIFICATE**

*This certificate is to be completed by a licensed physician only (and by the driver, as indicated).*

I certify that I have examined (print name of driver) \_\_\_\_\_, and, with knowledge of the driving duties, I find the above-named driver is medically capable of operating a taxicab or pedicab (circle one or both).

If applicable, this driver should operate a taxicab or pedicab only when:

- wearing corrective lenses
- wearing hearing aid
- other: \_\_\_\_\_
- not applicable / no conditions

The information I have provided regarding this examination is true and complete, and I certify that, at the time of this examination, the above-named driver has no known physical conditions or disabilities that would impair his/her safe operation of a taxicab or pedicab (circle one or both).

SIGNATURE OF MEDICAL EXAMINER	TELEPHONE	DATE
MEDICAL EXAMINER'S NAME (PRINT)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> ADVANCED <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PRACTICE ASSISTANT <input type="checkbox"/> NURSE <input type="checkbox"/> CHIROPRACTOR	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. AND ISSUING STATE		
SIGNATURE OF DRIVER	DRIVER'S LICENSE NO.	ISSUING STATE
ADDRESS OF DRIVER		
MEDICAL CERTIFICATE EXPIRATION DATE (TO BE DETERMINED AND INDICATED BY THE MEDICAL EXAMINER)		

*Sandpoint City Code 6-4-3-E requires a new medical certificate every two years.*