SANDPOINT
CITY HALL

APPLICATION FOR TAXI / LIMOUSINE DRIVER AUTHORIZATION

BUSINESS NAME: _____

BUSINESS LOCATION ADDRESS: _____

BUSINESS MAILING ADDRESS: _____

BUSINESS TELEPHONE: _____

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

NAME OF DRIVER: _____

DRIVER'S ADDRESS: _____

DRIVER'S HOME/MOBILE PHONE: _____

EMERGENCY CONTACT PHONE NUMBER: _____

NAME OF EMERGENCY CONTACT: _____

DRIVER'S DATE OF BIRTH: _____ DRIVER'S SOCIAL SECURITY #: _____

DRIVER'S 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: ***IF YOUR CURRENT CERTIFICATE IS EXPIRED OR YOU ARE APPLYING FOR THE FIRST TIME, YOU ARE REQUIRED TO SUBMIT, AT THE TIME OF APPLICATION, 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: _____

CASH _____ CHECK # _____ RECEIPT #_____

Sandpoint City Hall
1123 Lake St.
Sandpoint, ID 83864
(208) 263-3158

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)	☐ MD ☐ DO ☐ ADVANCED ☐ PHYSICIAN ASSISTANT ☐ PRACTICE NURSE ☐ 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**.*