

TAXI CAB LICENSE APPLICATION

FIRM NAME: _____

OWNER'S NAME: _____

MAILING ADDRESS: _____

RESIDENCE ADDRESS: _____

TELEPHONE NUMBERS: (Business) _____ (Residence) _____

AUTOMOBILE

YEAR, MODEL, MAKE: _____ COLOR: _____

SERIAL NUMBERS: _____

CURRENT LICENSE PLATE NUMBER: _____

(Attach a copy of current vehicle registration.)

INSURANCE

(Attach a certificate of insurance. Minimum coverage shall be \$100,000 property damage, \$100,000 / \$500,000 personal liability)

COMPANY: _____

POLICY NUMBER: _____

LOCAL AGENT: _____ TELEPHONE: _____

TERM OF INSURANCE: _____

INSPECTION CERTIFICATION

(Attach a certificate of inspection.)

COMPANY: _____ DATE: _____

COMMENTS: _____

This application is made pursuant to City of Sandpoint Code Title 6 Chapter 4 and all provisions contained therein. The annual fee of \$60.00 per vehicle is submitted herewith.

DATED THIS: _____ DAY OF _____, 20 _____.

Applicant's Signature

DATE FEE PAID _____ CASH _____ **or** CHECK # _____ RECEIPT # _____

**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 *\$50 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

I certify that I have examined _____ and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- wearing corrective lenses
- wearing hearing aid
- other: _____

The information I have provided regarding this physical examination is true and complete. I certify that at the time of this examination that _____ does not have any known physical conditions or disabilities that would impair safe operation of a taxicab.

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