OFFICE USE ONLY
LICENSE # _____
ISSUE DATE_____
EXPIRES _____

DEPARTMENT OF PUBLIC SAFETY
LICENSE SECTION

VEHICLE FOR HIRE DRIVER'S LICENSE APPLICATION

THE CITY OF COLUMBUS
MICHAEL B. COLEMAN, MAYOR
DEPARTMENT OF PUBLIC SAFETY

☐ **NEW** ☐ **RENEWAL**

☐ **LIVERY** ☐ **PEDICAB** ☐ **TAXI** ☐ **WHEELCHAIR/SPECIALTY**

APPLICANT INFORMATION		
Full Name:		Business Name:
Self Employed: YES NO		Name of Employer:
Date of birth:	SSN:	Federal ID:
Current address:		
City:	State:	Zip Code:
Phone Number:		Cell Phone:
Email:		
Ohio Driver's License Number:		Expiration Date:
Do you have six (6) months driving experience? (circle one) YES NO		
Sex: M F Race:	Height:	Weight: Hair: Eyes:
Are you a U.S. citizen? YES NO	Place of Birth:	
Are you a legal alien? YES NO	Alien Registration #	
If born outside of the U.S., proof of citizenship or alien registration card must be submitted.		
What licensed City of Columbus Vehicle for Hire Owner(s) do you work for?		
Have you had a City of Columbus license and/or permit revoked, suspended or refused within the last three (3) years? YES NO		
If yes, please explain:		
Have you ever been convicted of a felony? YES NO		
List all felony convictions in the United States over the past seven (7) years. If none, write "NONE".		
Are you on felony probation or parole? YES NO		If yes, date began:
Have you ever been required to register as a sexual offender? YES NO		If yes, date began:

MEDICAL SECTION

NOTE: Attending Physician or Nurse Practitioner, as set forth in Chapter 589.02 of the Columbus City Code and in the Rules and Regulations of the Vehicle for Hire Board, all drivers must meet the following requirements:

Eyesight: Have visual acuity (without glasses or by correction with glasses) of at least 20/30 in one eye and 20/100 in the other eye; field of vision not less than 45 degrees; and the ability to distinguish red, green and yellow.

Hearing: An average hearing loss in better ear <40 dB, without a hearing aid.

Medical Condition: Shall be free of epilepsy, vertigo and/or heart trouble.

CERTIFICATE OF PHYSICIAN/NURSE PRACTITIONER

I, _____ the undersigned licensed Physician or licensed Nurse Practitioner, do certify that
(Print licensed Physicians or Nurse Practitioners name & title)

_____ has been examined and that the following conditions were found to be true:
(Print Applicant Full Name)

Hearing	( ) Normal	( ) Abnormal	Epilepsy	( ) Normal	( ) Abnormal
Visual Acuity	( ) Normal	( ) Abnormal	Vertigo	( ) Normal	( ) Abnormal
Field of Vision	( ) Normal	( ) Abnormal	Heart Trouble	( ) Normal	( ) Abnormal
Color Vision	( ) Normal	( ) Abnormal			

Is applicant free from any infirmity that would prevent him/her from operating a vehicle for hire safely?

( ) YES ( ) NO – If NO, Please explain:

_____ _____
Attending Physician/Nurse Practitioner Signature Date

Physician/Nurse Practitioner Address:		Physician/Nurse Practitioner Stamp:
City:	State:	
Zip Code:		

ALL INFORMATION CONTAINED IN THIS APPLICATION IS SUBJECT TO DISCLOSURE AS A MATTER OF PUBLIC RECORD. ANY FALSE STATEMENT MADE OR GIVEN IN THIS APPLICATION SHALL RESULT IN DENIAL OR FUTURE REVOCATION OF THIS LICENSE, AS WELL AS CRIMINAL PROSECUTION UNDER CHAPTER 2321.13(A-3), (A-5) AND COLUMBUS CITY CODE 589.

State of Ohio, County of Franklin

_____, being duly sworn, deposes and says
(Print Applicant Name)

he/she is the individual making the foregoing application; that he/she is knowledgeable with respect to that which is to be licensed; that the answers to the foregoing questions and other statements contained herein are true of his/her own knowledge and belief.

_____
(Applicant Signature)

Swore to before me and subscribed in my presence this _____ day of _____, 20_____

_____
Notary or Agent of Director of Public Safety

MUST BE SIGNED, DATED and NOTARIZED