

APPLICATION FORM

AGING SERVICES FOR COMMUNITIES
TRANSPORTATION PROGRAM
212 1ST ST. SOUTH, PO BOX 7
MONTGOMERY, MN 56069
507-364-5663
Email: agingservices@frontiernet.net

NAME: (LAST, FIRST, MIDDLE) _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

DRIVER'S LICENSE NUMBER: _____

DATE OF EXPIRATION: _____ WHAT CLASS OF DRIVER'S LICENSE DO YOU HAVE: _____

YOUR FULL ADDRESS: _____

PHONE NUMBER: _____ Cell Number: _____

EMAIL: _____

EMERGENCY CONTACT PERSON & PHONE: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR CRIME? YES NO

IF YES, EXPLAIN: _____

HAVE YOU HAD ANY ACCIDENTS IN LAST 12 MONTHS, IF YES PUT DATE AND A BRIEF EXPLANATION: _____

HAVE YOU HAD A DWI OR DUI IN THE LAST 5 YEARS? YES NO
ARE YOU ON SIEZURE MEDICATION? YES NO
ARE YOU ON MEDICATION THAT WOULD IMPAIR YOUR DRIVING?
YES NO

If you are on an anticonvulsive medication you are not eligible to be a volunteer driver for ASC. If once you are volunteering and the doctor prescribes an anticonvulsive medication or you have a seizure you are to notify ASC and remove yourself from being a volunteer driver.

DO YOU HAVE EXPERIENCE IN DRIVING FOR OTHER PROGRAMS OR BUSINESSES?

YOUR MOTOR VEHICLE INSURANCE CARRIER, PHONE AND ADDRESS:

AUTOMOBILE DESCRIPTION: MAKE AND MODEL: _____
COLOR OF AUTOMOBILE: _____,
LICENSE PLATE NUMBER: _____,
DRIVER'S LICENSE NUMBER: _____,
2 DOOR _____, 4 DOOR _____, VAN _____, TRUCK _____, CAR _____

CIRCLE DAYS OF THE WEEK AVAILABLE TO DRIVE: SUNDAY MONDAY
TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

WHERE WOULD YOU BE WILLING TO DRIVE: IN COUNTY ONLY _____
TO ROCHESTER _____ TO THE TWIN CITIES _____ OUT OF STATE _____
TO MANKATO _____ ANY WHERE _____

** PLEASE ATTACH A COPY OF YOUR INSURANCE FACE SHEET WITH THE TYPE OF INSURANCE AND THE AMOUNTS FOR LIABILITY/COMPREHENSIVE/COLLISSION (BY MINNESOTA LAW YOU ONLY HAVE TO CARRY LIABILITY). ASC'S EXCESS AUTOMOBILE LIABILITY INSURANCE BECOMES EFFECTIVE IF YOU CARRY \$50,000

MY SIGNATURE GUARANTEES THAT THE INFORMATION ABOVE IS TRUE, AND THAT I WILL USE MY PERSONAL AUTOMOBILE IN VOLUNTEER SERVICE, I WILL ARRANGE TO KEEP IN EFFECT MY AUTOMOBILE LIABILITY INSURANCE, NOTIFY ASC IF I HAVE A SEIZURE, DWI OR START TAKING AN ANTICONVULSIVE MEDICATION AND LASTLY, I GIVE PERMISSION TO CONDUCT A BACKGROUND CHECK.

SIGNATURE: _____ DATE: _____