



COMMUNITY DEVELOPMENT DEPARTMENT

Code Administration Division

129 North Second Street, 2nd Floor Yakima, Washington 98901

Phone (509) 575-6126 • Fax (509) 576-6576 Email: codes@yakimawa.gov

TAXI DRIVER'S LICENSE APPLICATION

YMC Chapter 5.78

Fees: Temp Driver License/App Fee (non-refundable)	\$10.00
Driver's License	\$11.00
Background Check(WATCH)	\$11.00
Fingerprinting may be required:	\$10.00 (at Yakima Police Department)
WSP	\$58.00 (Money order made out to WSP)

Applicant Info:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ How long at this address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Email: _____

Date of Birth: _____ Place of Birth: _____

Drivers License #: _____ State: _____ Exp: _____ SSN #: _____

Height: _____ Weight: _____ Marital Status: _____ Hair Color: _____ Eye Color: _____

Taxi Driver History:

Prospective employer: _____

List previous places of residency for the last five years: _____

Last place of employment: _____

Have you previously been issued a taxi driver's license? Yes No

If so, where?: _____

Have you ever had a driver's license in another state? Yes No

If so, please give license # and state: _____

Has your driving privilege ever been suspended or revoked in this or any other state? Yes No

If so, please explain: _____

Have you ever been convicted of a crime, other than minor traffic violation? If so, list each conviction, approximate date of conviction, name and location of court, the crime charged and final disposition:



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Health Certification (to be completed by a Physician):

Vision:..... Good Fair Poor

Patient is now in what state of health?..... Good Fair Poor

Does patient have heart trouble?..... Yes No

Does patient have history of epilepsy?..... Yes No

Has patient ever been troubled by vertigo?..... Yes No

Has patient lost much weight in the past year?..... Yes No

Has patient been seen by a physician within the past year? Yes No

Does patient have any physical or mental condition likely to render patient unfit to drive a sightseeing vehicle?

Yes No

If yes, please explain:_____

Does the patient have any type of illness? Yes No

If yes, please explain:_____

Name and address of physician:_____

Signature of Physician:_____ Date:_____