##  Motor Vehicle Authorization

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| Authorization Agreement |
| I hereby authorize **Quantum Recruiters** to obtain a report of my driving record from the Department of Motor Vehicles. I understand that this document shall be kept on file and may be used at any time during my employment to procure an investigative report and that the information obtained may be shared with our clients. I HEARBY WAIVE, RELEASE AND DISCHARGE TO THE MAXIMUM EXTENT PERMITTED BY LAW, QUANTUM RECRUITERS, INC, ITS EMPLOYEES, AND INDIVIDUALs OR AGENCIES OBTAINING INFORMAITON FOR QUANTUM RECRUITERS. I agree to notify Quantum Recruiters should I incur any new infractions on my driving record (no matter how minor) immediately. I also agree to notify Quantum Recruiters should my automobile insurance coverage change or be canceled for any reason while employed with Quantum and operating a motor vehicle in my position with Quantum Recruiters. I accept full responsibility for any damages that may result from my negligence in operating a motor vehicle if I fail to inform Quantum Recruiters of any changes to my driving record or automobile insurance.. All changes must be provided to Quantum Recruiters in writing. I will not be authorized to operate any vehicle for the City if I do not have a valid driver's license or automobile insurance coverage under my name. This agreement will remain in effect until **Quantum Recruiters** receives a written notice from me stating I will no longer qualify under this authorization. |
| Information |
| Employee Name (*please print*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver's License # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDL: Yes No Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Primary Policy Holder if Different Than Above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Please attach copy of insurance card* |
| Signature |
| Authorized Signature: |  | Date: |  |
| Printed Name:  |  | Date: |  |
| Information

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| FOR OFFICE USE ONLY |

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| *Quantum Representative: Date:* |

Information |
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