



New York State Department of Motor Vehicles
ARTICLE 19-A BUS DRIVER APPLICATION



(Complete all parts of this form. Please print or type.)

Send original to Driver Program Regulation, Customer Service Unit; keep a copy in your driver 19A file.)

| CARRIER INFORMATION | | | | DRIVER INFORMATION | | | |
|--|--|------------------|----------|--------------------------|--|-------------------|---|
| Federal Employer Identification Number | | | | Social Security Number | | | |
| Company Name | | | | Name (Last) | | First | M.I. |
| d.b.a. | | | | Date of Birth | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (No. and Street) | | | | Address (No. and Street) | | | |
| City | | State | Zip Code | City | | State | Zip Code |
| County | | Telephone Number | | County | | Telephone Number | |
| Name of Article 19-A Contact Person | | | Title | License Class | | State of Issuance | License Expiration Date |
| Is this employer/carrier a school bus carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Client ID # | | | |

ADDITIONAL DRIVER INFORMATION
 Provide your employment, accident, and conviction history and answer the questions below. If necessary, attach additional pages.

1. Have you qualified as a school bus driver under ARTICLE 19-A? Yes No If "yes", give month and year of qualification _____

2. Are you a certified ARTICLE 19-A examiner? Yes No
 If "yes", give certificate number _____ and expiration date _____.

EMPLOYMENT (Start with your most recent employment, and include work history for the past 3 years):

| Employer Name and Address | What were the date(s) of your employment? (From - To) | Your job title |
|---------------------------|--|----------------|
| | | |
| | | |
| | | |

ACCIDENTS (Start with your most recent accident, and include accidents within the past 3 years):

| Date of Accident | Location (City, State, Zip Code, County) | Was there personal injury or property damage? If "YES", indicate the dollar amount of damage to each vehicle, and the number of people injured. | What type of vehicle were you driving? |
|------------------|---|--|--|
| | | | |
| | | | |
| | | | |

CONVICTIONS (Start with your most recent conviction, and include all criminal convictions):

| Date of Violation | Location (City, State, Zip Code, County) | Date of Conviction | Of what charge were you convicted? | If a vehicle was involved, what type of vehicle were you driving? |
|-------------------|---|--------------------|------------------------------------|---|
| | | | | |
| | | | | |
| | | | | |

DRIVER AFFIRMATION: To the best of my knowledge, the information I have given on this application is true.

Signature of Driver _____ Date _____

EMPLOYER CERTIFICATION: This application has been reviewed together with the driver abstract and medical examination (form DS-874) and the applicant is hereby classified as a "conditional driver" as defined in Section 6.2(r) and in accordance with the requirements of Sections 6.3 and 6.4 of the regulations of the Commissioner of Motor Vehicles. Final approval of employment is subject to the applicant meeting the requirements of Article 19-A of the New York State Vehicle and Traffic Law.

Signature of Employer/Agent _____ Date _____

Driver Information

| | | |
|------------------------|--|------|
| Name (Last) | First | M.I. |
| Social Security Number | Employer/Carrier Federal Employer I.D. Number: | |

SCHOOL DISTRICT/OTHER CONTRACT INFORMATION

For EACH contract served, provide the following information. If you need more space to report contract information, you may photocopy this page and attach the copies to this form.

Check **ALL** appropriate boxes to identify the type of institution/client groups served:

- Academic Day Care Mentally Disabled Vocational Nursery/Pre-School
 Camp Religious Physically Disabled Other (Specify) _____

| | | | | |
|--|--------------------------------------|-------------------------|--------|----------------------|
| Federal Employer I.D. Number of Contract | School District Code (if applicable) | | | |
| Contract Name | | | | |
| Mailing Address (Include Street & No.) | | | | |
| City | State | Zip Code | County | Telephone Number () |
| Name of Article 19-A Contact Person | | Title of Contact Person | | |

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All questions pertaining to this form and/or the Article 19-A Program should be directed to:

New York State Department of Motor Vehicles
 Driver Program Regulation
 Customer Service Unit
 6 Empire State Plaza Rm 220C
 Albany NY 12228
 (518) 473-9455