

AUTHORIZATION FOR THE RELEASE OF DRIVING RECORD INFORMATION

NAME OF INDIVIDUAL:	
NAME OF EMPLOYER:	
INSURANCE COMPANY:	
INSURANCE AGENT OR BROKER:	

I (*the individual shown above*) understand and consent that a copy of my driving record will be obtained from the appropriate state department of motor vehicles.

These records will be obtained for the purposes of underwriting insurance or adjusting claims on behalf of the Employer or potential Employer listed above. I understand that the Employer may also use such driving record information to determine my eligibility for employment or continued employment. I further understand that the information may be shared between the Employer, Insurance Company and/or Insurance Broker shown above.

This consent shall be effective as of the date show below and shall be a continuing consent throughout the period during which I am an applicant for employment or an employee of the listed Employer. I do not consent to the sharing of this information with persons or entities other than those shown above.

DATE OF THIS AUTHORIZATION:	
SIGNATURE OF INDIVIDUAL:	
DATE OF BIRTH:	
DRIVERS LICENSE NUMBER:	
TYPE OF LICENSE:	<input type="checkbox"/> Standard License <input type="checkbox"/> Commercial License (CDL)
STATE GRANTING LICENSE:	

