DL-503 (7-11)

# REQUEST FOR DRIVER INFORMATION

The most current version of this form can be found at www.dmv.state.pa.us

**PLEASE TYPE OR PRINT IN BLUE OR BLACK INK**

**DO NOT SEND CASH • SEE REVERSE FOR INSTRUCTIONS**

pennsylvania
DEPARTMENT OF TRANSPORTATION

Bureau of Driver Licensing
P.O. Box 68695
Harrisburg, PA 17106-8695

CHECK (✔) ONE ONLY:

- ☐ BASIC INFORMATION: **$5.00 FEE** *(Driver history is* **not** *included)*
- ☐ 3 YEAR DRIVER RECORD: **$5.00 FEE**
- ☐ 10 YEAR DRIVER RECORD: **$5.00 FEE** *(Employment Purposes Only)*
- ☑ FULL HISTORY: **$5.00 FEE**
- ☐ CERTIFIED DRIVER RECORD: **$10.00 FEE**
- ☐ COPY OF DOCUMENT FROM FILE (MICROFILM): **$5.00 FEE**
- ☐ CERTIFIED COPY OF DOCUMENT FROM FILE: **$10.00 FEE**

**You may obtain a copy of your own 3 year, 10 year and/or Full History Driving Record on PennDOT'S website at www.dmv.state.pa.us**

## A REQUESTER INFORMATION

NAME/COMPANY: **James E. Van Zandt VAMC**

ADDRESS: **2907 Pleasant Valley Blvd**

CITY: **Altoona** STATE: **PA** ZIP CODE: **16602**

DAYTIME TELEPHONE NUMBER *(REQUIRED)*: **(814) 940-7833**

RELATIONSHIP TO DRIVER *(REQUIRED)*: **Employer**

SIGNATURE X

NOTARIZATION NOT REQUIRED WHEN REQUESTING YOUR OWN RECORD

## B END USER OF INFORMATION BEING REQUESTED

NAME/COMPANY: **James E. Van Zandt VAMC**

ADDRESS *(P.O. Box not acceptable), need to provide physical location of business/residence*: **2907 Pleasant Valley Blvd**

CITY: **Altoona** STATE: **PA** ZIP CODE: **16602**

DAYTIME TELEPHONE NUMBER *(REQUIRED)*: **(814) 940-7833**

RELATIONSHIP TO DRIVER *(REQUIRED)*: **EMPLOYER**

## C DRIVER INFORMATION

NAME: LAST FIRST INITIAL

ADDRESS

CITY

STATE ZIP CODE

PHONE NUMBER

| DATE OF BIRTH | | | DRIVER NUMBER |
|---|---|---|---|
| MONTH | DAY | YEAR | |
| | | | |

## D AFFIDAVIT OF INTENDED USE

Intended Use of the Information Requested: **CHECK ONLY ONE**

- ☐ **B=Driver Release** *(Driver must complete Section E.)*
- ☐ **C=Credit Business** *(Legitimate Business need in connection with a business transaction initiated by the driver.)*
- ☐ **C=Credit Potential Investor, Server or Current Insurer** *(In connection with an assessment of the credit/payment risks associated with an existing credit obligation.)*
- ☑ **E=Employment** *(To support the hiring or the continuation of employment. Driver must complete Section E.)*
- ☐ **R=Insurance Company** requesting record of person it intends to insure, now insures, or has rejected for insurance.
- ☐ **K=Court Order** must be attached. *(A subpoena issued in compliance with Pa. R.C.P. 4009.21 will be accepted in lieu of a court order).*
- ☐ **L=Attorney** representing driver identified in Section C *(Driver must complete Section E.)*

I hereby Certify that _____
PRINTED NAME OF REQUESTER

will use the driver record abstract(s) required pursuant to Section 6114 of the Pennsylvania Vehicle Code, for the purpose checked above only and no other reason. This affidavit is filed in compliance with Section 607 of the Fair Credit Reporting Act. I/We have read and signed this form after its completion, and I/We swear or affirm that the statements made herein are true and correct, and that any statement made on or pursuant to this form is subject to the penalties of 18 Pa C.S. Section 4903(a)(2) (relating to false swearing), which shall include punishment of a fine not exceeding $5,000, or to a term of imprisonment of not more than two years, or both.

X _____
SIGNATURE OF REQUESTER

Title _____

## E DRIVER RELEASE

I _____ hereby request
NAME OF DRIVER

the Department of Transportation to furnish a copy of my PA Driver's Record to _____
NAME OF PERSON/COMPANY

X _____
SIGNATURE OF DRIVER DATE

## F MICROFILM

| TYPE OF DOCUMENT | DATE OF VIOLATION |
|---|---|
| | |

*(see list of available documents below)*

**Documents Available:**

- Citations
- Court Certifications
- Applications
- License Renewals
- Judgments
- Suspension Credit Affidavits
- Suspension/Revocation Letters
- Restoration Letters
- Rescind Letters
- Department Hearing or Exam Notice

**MESSENGER NO.**

## NOTARIZATION

SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY YEAR

X _____
SIGNATURE OF PERSON ADMINISTERING OATH

SEAL

SIGN IN PRESENCE OF NOTARY

DL-503 (7-11)

## INSTRUCTIONS

1. **To request your own record**, complete Sections A & C only. Notarization is NOT required.
2. **To request a record other than your own**, complete Sections A, C, and D. Section E must contain the driver's signature if block **B, E or L is checked in Section D. If the Requester is obtaining the information on behalf of someone else, Section B must also be completed.**
3. **PRINT OR TYPE** all requested information on the front of the form. Submitting ONLY a name and address does not provide enough information for a proper search of the driver files.
4. A non-refundable fee is required for each request. If the Bureau has no record for the information requested or the data supplied is insufficient, the fee will be applied to the cost of the search.
5. **If requesting a microfilm copy of a document,** also complete Section F. You must be specific in providing the type and date of the document. If there are several citations on the record, the cost is $5.00 per citation. You need to provide the date of the violation/action to clearly identify the citation(s) requested.
6. Check the type of record requested at the top of the form and make check or money order payable to "PennDOT." **DO NOT SEND CASH.** Attach your check or money order and send to:

BUREAU OF DRIVER LICENSING
DRIVER RECORD SERVICES
P.O. BOX 68695
HARRISBURG, PA 17106-8695

***For overnight and other special mail:***

BUREAU OF DRIVER LICENSING
DRIVER RECORD SERVICES
1101 SOUTH FRONT STREET 3RD FLOOR
HARRISBURG PA 17104-2516

## DESCRIPTION OF INFORMATION AVAILABLE

BASIC INFORMATION..... Includes name, address, driver number, date of birth and class of license.
($5.00 fee)

3 YEAR RECORD* ..... Includes name, address, driver number, date of birth, class, license status, Departmental actions and violations for the past 3 years from the date request is processed. **You can obtain a copy of your own record on PennDOT's website at www.dmv.state.pa.us**
($5.00 fee)

10 YEAR RECORD* ..... Includes name, address, driver number, date of birth, class, license status, Departmental actions and violations for the past 10 years from the date request is processed. A 10-year record is for employment purposes only. **You can obtain a copy of your own record on PennDOT's website at www.dmv.state.pa.us**
($5.00 fee)

FULL HISTORY ..... Includes name, address, driver number, date of birth, class, license status, Departmental actions and violations for the **complete** history of the driver on file in Pennsylvania.
($5.00 fee)

CERTIFIED RECORD..... Includes name, address, driver number, date of birth, class, license status, Departmental actions and violations for the **complete** history of the driver on file in Pennsylvania certified by the Department.
($10.00 fee)

MICROFILM
DOCUMENT..... Copies of documents retained by the Department are available for purchase from the microfilm file. You must be specific as to the type of document and the date of the violation/action.
($5.00 fee)

CERTIFIED COPY
OF DOCUMENT ..... Copies of documents from the microfilm file that have been certified by the Department.
($10.00 fee)

## IMPORTANT INFORMATION CONCERNING THE USE OF DRIVER INFORMATION

- Driver record information is confidential and restricted information and the Requestor/End User is responsible for establishing procedures to protect the confidentiality of these records.
- Driver record information can only be used for the purpose stated in Section D.
- Driver record information cannot be sold, assigned, or otherwise transferred to any party, other than the End User.
- PennDOT retains exclusive ownership of all driver record information and the Requestor/End User shall not combine and/or link in with any other data on any database except as may be required by law.
- The driver record information cannot be used for direct mail advertising or any other type or types of mail or mailings.
- The driver record information cannot be disseminated or published on the Internet without the express written permission of PennDOT.
- PennDOT reserves the right to audit each request for driver record information. If the Requestor/End User is found to have requested driver record information for an unauthorized purpose, access to Pennsylvania driver record information will be terminated.

* Businesses who obtain driver records for the purpose of employment or insurance are now able to obtain and print these records, in real time, through our enhanced Online Services.

If you are an employer or insurance company/agent and are interested in becoming an authorized Online business user, please visit our website at www.dmv.state.pa.us and click on "Online Business Services" for more information.

OF 345
(11/85)
Office of Personnel Management
FPM CHAPTER 930

# PHYSICAL FITNESS INQUIRY FOR MOTOR VEHICLE OPERATORS

| 1. Name *(Last, First, Middle)* | 2. Date of Birth *(Month, Day, Year)* | 3. Title of Position |
|---|---|---|
| | | |

| 4. Home Address *(Number, Street or RFD, City, State and Zip Code)* | 5. Employing Agency |
|---|---|
| | |

6. Have you ever had or have you now: *(Place check at left of each item.)*

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Poor vision in one or both eyes | ☐ | ☐ | Arthritis, rheumatism, swollen or painful joints |
| ☐ | ☐ | Eye disease | ☐ | ☐ | Loss of hand, arm, foot, or leg |
| ☐ | ☐ | Poor hearing in one or both ears | ☐ | ☐ | Deformity of hand, arm, foot, or leg |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Nervous or mental trouble of any kind |
| ☐ | ☐ | Palpitation, chest pain, or shortness of breath | ☐ | ☐ | Blackouts or epilepsy |
| ☐ | ☐ | Dizziness or fainting spells | ☐ | ☐ | Sugar or albumin in urine |
| ☐ | ☐ | Frequent or severe headaches | ☐ | ☐ | Excessive drinking habit (Alcohol) |
| ☐ | ☐ | High or low blood pressure | ☐ | ☐ | Other serious defects or diseases |
| ☐ | ☐ | Drug or narcotic habit | ☐ | ☐ | |

7. If you answer is "Yes" to one or more of the above questions, explain fully in this space, indicating date of original condition and current status:

8. (A) Do you wear glasses (or contact lenses) while driving? ..... ☐ YES ☐ NO

(B) Do you wear a hearing aid? ..... ☐ YES ☐ NO

## PRIVACY ACT STATEMENT

Solicitation of this information is authorized by 40 U.S.C. 491 and 5 CFR Part 930 Subpart A, which require OPM to regulate Federal employees use of Government-owned or -leased motor vehicles. It is used to ascertain the physical fitness of Federal employees, whose jobs require authorization to drive Government-owned or -leased vehicles. It is also used in the renewal of authorizations for all such employees.

Based on the information provided, employees may be referred for a medical examination before being granted an initial authorization or a renewal. The disclosure of this information is mandatory when an employee's job requires driving a Federal motor vehicle and is voluntary otherwise. However, failure to complete when requested may result in you not being permitted to operate a Government vehicle.

| **Certification:** I certify that my answers to the above are full and true, and I understand that a willfully false statement or dishonest answer may be grounds for cancellation of my eligibility or my dismissal from the service and is punishable by law. | 9. Signature | 10. Date Signed *(Month, Day, Year)* |
|---|---|---|
| | | |

## REVIEW AND CERTIFICATION BY DESIGNATED OFFICIAL

**Certification:** I certify that I have reviewed this physical fitness inquiry form and other available information regarding the physical condition of the applicant, and that I have made the following determination:

☐ 1. There is no information on this form or otherwise available to indicate that the applicant should be referred for physical examination.

☐ 2. On the basis of items checked on this form or other information, this applicant must be referred for physical examination before authorized to operate a Government-owned or -leased motor vehicle or current authorization is renewed.

☐ 3. Items checked on this form or otherwise available do not warrant referral for medical examination because of the following facts:

| Signature of Designated Official | Date Signed *(Month, Day, Year)* |
|---|---|
| | |

JetForm

*OMB Number 2900-0090*
*Estimated Average: 15 min.*

# Department of Veterans Affairs

# APPLICATION FOR VOLUNTARY SERVICE

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The form is used to assist personnel of both voluntary organizations, which recruit volunteers from their membership, and the VA in the selection, screening and placement of volunteers in the nationwide VA Voluntary Service program. The volunteer program supplements the medical care and treatment of veteran patients in all VA facilities.

**PRIVACTY ACT INFORMATION:** The information requested on this form is solicited under the authority of 38 U.S.C. 513 and will be used in the selection and placement of potential volunteers in the VA Voluntary Service Program. The information you supply may be disclosed outside VA as permitted by law; possible disclosures include those described in the 'routine uses' identified in the VA system of records 57VA125 Voluntary Service Records-VA, published in the Federal Register in accordance with the Privacy Act of 1974. The routine uses include disclosures: in response to court subpoenas, to report apparent law violations to other Federal, State or local agencies charged with law enforcement responsibilities, to service organizations, employers and Unemployment Compensation Offices to confirm volunteer service, and to congressional offices at the request of the volunteer. Disclosure of the information is voluntary, however, failure to furnish the information will hamper our ability to arrange the most satisfactory assignment for you and the Department of Veterans Affairs.

| NAME (Last, First, Middle Initial) | ADDRESS (Street, City, State and Zip Code) | DATE |
|---|---|---|
| | | |
| Telephone Number / Email Address (Optional) | | Date of Birth |
| | | SEX ☐ M ☐ F |
| ORGANIZATION MEMBERSHIP(S) Unit, Post, Chapter, if affiliated) | ASSIGNMENT PREFERENCES 1. 2. 3. | |

EXPERIENCE AND TRAINING (special skills/abilities)

| RESTRICTIONS, LIMITATIONS OF SERVICE (Health concerns, medications, allergies, etc.) | AVAILABILITY (Days and times) |
|---|---|
| | |

IN CASE OF EMERGENCY PLEASE CONTACT (name, relationship, phone number)

Monetary Waiver: I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compensation basis" for an indefinite period. I understand that this waiver applies only to remuneration (compensation) for specific services rendered in the VA Voluntary Service (VAVS) Program and is not related to any other VA services or benefits to which I may be entitled. (**NOTE:** VA has entered into this agreement by the authority of 38 U.S.C., Section 513. This agreement may be canceled by either party upon written notice.) I hereby accept the volunteer appointment(s) as outlined above.

Volunteer's Signature _____ Date _____

I hereby appoint this applicant as a VA without-compensation employee subject to the provisions on this application. The above individual has been provided basic and assignment specific orientations which have been documented in the official volunteer folder located in the VA Voluntary Service Office.

VAVS Program Manager - Appointing Official Signature _____ Date _____

**OFFICE USE ONLY**

1. SUPERVISOR _____ 2. SUPERVISOR PHONE NUMBER _____

3. ORIENTATIONS _____ 4. UNIFORM _____

| COMMENTS | NAME AND TITLE OF REVIEWER | DATE |
|---|---|---|
| | | |

**VA FORM** MAY 2007 **10-7055** EXISTING STOCK OF VA FORM 10-7055, AUG 2006, WILL BE USED.

**NOTE TO STUDENTS AND PARENTS**: The VA medical center is a federal building, and, as such, must be open to the public. Our employees, patients and volunteers come from diverse backgrounds. Eligible veterans are entitled to services offered by VA, even if they have had problematic incidents in their past - unless the law specifically disqualifies them. Our job is to provide veterans care and to protect our employees, patients and volunteers as that care is provided.

**STUDENT VOLUNTEER:** If accepted, I agree to adhere to the policies and procedures of this VA healthcare facility and to respect the confidentiality of information pertaining to the patients and their treatment. If a patient, staff member, volunteer, and/or visitor is abusive, makes inappropriate gestures, advances or conversation, that is in a manner which makes me feel uncomfortable, I will immediately inform my supervisor or a VAVS staff member.

Signature_____

Date _____

**PARENT/GUARDIAN:** The above named student has my consent as parent/guardian to serve as a Student Volunteer in this VA healthcare system. I have read the above agreement as signed by my student and understand their obligation to the program if they are accepted into the VAVS Student Volunteer Program. I also grant permission for my child to receive emergency medical treatment if injured while volunteering.

Signature_____

Date _____

NOTE: Completion of this application does not guarantee acceptance into this program.

# VOLUNTEER TRANSPORTATION NETWORK

## REGISTRATION SHEET

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SOC. SECURITY #: _____

DATE OF BIRTH: _____ PHONE #: _____

ORGANIZATION: _____

DRIVER'S LICENSE #: _____ STATE: _____

COUNTY WHERE YOU WILL BE TRANSPORTING: _____

EXPIRATION DATE: _____

INSURANCE DATA VERIFIED BY: _____ ON: _____

**NEXT OF KIN INFORMATION**

NAME: _____

RELATIONSHIP: _____

PHONE #: _____

**Monetary Waiver:** I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compensation basis" for an indefinite period. I understand that this waiver applies only to remuneration (compensation) for specific services rendered in the VA Voluntary Service (VAVS) Program and is not related to other VA services or benefits to which I may be entitled. (Note: VA has entered into this agreement by the authority of 38 U.S.C., Section 513. The agreement may be cancelled by either party upon written notice.)

_____

Volunteer's Signature Date

OFFICE USE ONLY

CODE:

INITIALS: DATE: