

Shriners Hospital Patient Transportation

AINAD ROAD RUNNERS DRIVER APPLICATION

NAME:	
First	Last
SPOUSE NAME:	
ADDRESS:	
Street	City
State Zip	Phone
	E-mail
DDIVEDCLIC #.	CTATE. CLASS
DRIVERS LIC. #:	STATE:CLASS:
RESTRICTIONS:	
RESTRICTIONS:	
DATE OF BIRTH:/: AGE	
RETIRED:: WORKING:	- HOURS WORKING PER WEEK:
DATE THIS APPLICATION SUBMITTEI	D:
How long have you been a Van driver for A	AINAD?
How many trips have you made in our Van	?
What is your preference on which hospital	you might drive to?
St. Louis:Chi	cago:
How many trips per month are you willing	to take?
Would you use your personal vehicle to tra	
Louis Hospital?	
Have you received or participated in any di	rivers orientation classes before?
Do you think a first aid or safety class is ne	
All drivers are to fill out an application, bo	th current and new drivers.
Any Comments:	