GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
APPLICATION FOR AUTHORIZATION TO OPERATE
GOVERNMENT LEASED/OWNED VEHICLES

NAME: ______________________________ **TELEPHONE #:** __________________
Printed

WORK LOCATION (*Administration/Office/Program*): ______________________________

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DRIVER'S PERMIT #: ______________ **STATE:** ___ **EXPIRATION DATE:** ________

A COPY OF YOUR STATE DRIVER'S LICENSE MUST ACCOMPANY THIS FORM

______________________________________ ______
(*Employee Signature*) **(*Date*)**

IMMEDIATE SUPERVISOR'S AUTHORIZATION:

I hereby authorize the above-named Department of Health employee to drive a government owned/leased vehicle for official government business.

______________________________________ ______
(*Supervisor Signature*) **(*Date*)**

SUPERVISOR'S NAME & TITLE (*printed*): ____________________________________

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ADMINISTRATION'S AUTHORIZATION:

______________________________________ ______
(*Administrator's Signature*) **(*Date*)**

ADMINISTRATION APPROVAL-NAME & TITLE (*printed*): _________________________

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This document requires Administration approval and must be signed by either the Senior Deputy Director, the Chief of Staff, or the Administrative Services Officer

Please Return To:

David Phifer
899 North Capitol Street, NE, 1ST Floor
Washington, D.C. 20002
(202) 724-7492
david.phifer@dc.gov