SCHOOL BUS OR ALTERNATIVE VEHICLE LICENSE INFORMATION REQUEST

Wisconsin Department of Transportation
MV3740 2/2019 Trans. 112 Wis. Admin. Rule

WisDOT Employees ONLY: Email form with *any* **YES** answers to: dmed@dot.wi.gov. Forms with *only* **NO** answers can be scanned into the system under document type MV3740.

Please print

Applicant Name – First | Middle Initial | Last | Birth Date (m/d/yyyy)

Wisconsin Driver License Number or Social Security Number – *For Verification Purposes*

YES	NO	
☐	☐	Have you ever been convicted of a crime or other offense listed under s.343.12(7) Wis. Stats. or Ch. Trans. 112.15 WI Admin. Code within the time frame listed on ply 1 of this form?
☐	☐	Are you currently listed on any sex offender registry?
☐	☐	Are you currently listed on any nurse abuse registry?

Explain "YES" answers

YES	NO	
☐	☐	Have you been a resident in another state within the previous 2 years? If you checked "YES", list all other state(s) in which you have been a resident during the previous 2 years.

States:

APPLICANT STATEMENTS

With issuance of a Wisconsin School Bus License or as an alternative vehicle driver, I agree to report in writing to my employer, within 10 days:

1) Any accident in which I was involved as the operator of <u>any</u> motor vehicle regardless of who was at fault or if citations were issued;
2) Any conviction or operating privilege withdrawal listed under s.343.12(7) Wis. Stats. or Ch. Trans. 112.15 WI Admin. Code that makes the operator ineligible to operate a motor vehicle to transport pupils;
3) If I hold a school bus endorsement, any incidents that would disqualify me for holding that endorsement;
4) Any suspension or revocation of my operating privilege;
5) Any cancellation of my school bus endorsement by this state or another jurisdiction.

I understand that I may not falsify or provide incomplete information in respect to any material fact on this or any other background information form.

I also understand that it is my responsibility to report any new medical condition or a medical condition that has significantly changed since my last report.

X
(Applicant Signature) (Date – m/d/yyyy)

For WisDOT/Employer USE ONLY – *Please check one*

☐ Original Application ☐ Interim CIB Check
☐ Renewal ☐ CCAP Check

Electronic form: Fill out, print, and make desired copies.
Paper form: White – WisDOT, Pink – Employer