



S A C O G

Sacramento Area
Council of
Governments

**VANPOOL DRIVER/BACK-UP DRIVER
MEDICAL EXAMINATION REIMBURSEMENT REQUEST**

Return this completed request to:
SACOG, 1415 L Street, Suite 300, Sacramento, CA 95814
Phone: 916-321-9000; Fax: 916-321-9551

Please print or type:

Driver's Name _____ Daytime Phone (____) _____

Driver's License # _____ State _____ Expiration Date _____

Medical payment reimbursement will be made payable to (check one):

Driver Company/Organization/Vanpool Coordinator _____

Mailing Address _____

City _____ State _____ Zip _____

Attention _____

Date Medical Exam Completed _____

PLEASE FILE THIS WITHIN FOUR MONTHS AFTER EXAMINATION DATE.

I certify that I or my company/organization/vanpool coordinator have paid for a DOT Medical Examination to qualify me as a Vanpool Driver according to the State of California Vehicle Code Statutes. I have attached the following as verification (both items must be included):

- 1. ORIGINAL receipt for examination**
- 2. Photocopy of my Medical Examination Report (Form DL51A) signed by the examining physician**

I also certify that this is my FIRST AND ONLY application for a medical reimbursement. NO OTHER APPLICATION WILL BE SUBMITTED HEREAFTER.

Driver's Signature

Date

Company/Organization/Vanpool Coordinator Authorized Signature

Date

Office Use Only

I recommend approval for reimbursement of \$ _____ (\$50.00 maximum).

Project Manager: _____ Date: _____

Work Element: _____ Task Number _____ Applicant SSN provided? Y N