COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
AUTHORIZED COUNTY VEHICLE DRIVER

_____ _(___)_____
FACILITY VEHICLE COORDINATOR PHONE

SUBMIT TO: DEPARTMENTAL VEHICLE COORDINATOR
ADMINISTRATIVE SUPPORT BUREAU
550 SOUTH VERMONT AVENUE, 2ND FLOOR
LOS ANGELES, CALIFORNIA 90020

_____ _____
FACILITY NAME, SERVICE AREA, BUREAU, DIVISION ADDRESS

NAME OF DRIVER	EMPLOYEE NUMBER	LICENSE NUMBER	CLASS OF LICENSE	EXPIRATION DATE	LICENSE EXPERATION DATE VERIFIED BY	COMMENTS OR RESTRICTIONS

_____ _____ _____
PRINTED NAME OF ADMINISTRATIVE HEAD SIGNATURE OF ADMINISTRATIVE HEAD DATE