Granby Ambulance Association
1 Pegville Rd.
Granby, CT 06035
(860) 653-6535
www.granbyambulance.org
Authorization for
Motor Vehicle Check

Last Name: _____ Maiden Name: _____ First: _____ Initial: ___
Street Address: _____ City: _____ State: ____ Zip: _____
Date of Birth: ___/___/____ Social Security Number: _____-_____-_____

Motor Vehicle Check

I authorize Granby Ambulance Association, Inc. to contact the Granby Police Department and/or the Department of Motor Vehicles of the State of Connecticut, or any similar motor vehicle agency of a state where I have had a driver's license or privileges, for the purpose of identifying any restrictions, violations or accidents which might restrict or otherwise interfere with my ability to operate an ambulance. Motor vehicle checks will be done in all states where I have lived as far back as that state's law allows.

Signature: _____ Date: _____

Print Name: _____