



City Of Union City Department Of License Inspector



TAXI LICENSE REQUIREMENTS

- (1) \$30.00 TAXI LICENSE FEE FOR THE RECORD ROOM
(2) SOCIAL SECURITY CARD
(3) PHOTO IDENTIFICATION
(4) 2 PROOFS OF RESIDENCE
(5) 2 PASSPORT PHOTOS
(6) ALL FINGERPRINTING OF APPLICANTS WILL BE CONDUCTED BY MORPHO TRAK AS PER NEW REQUIREMENTS IMPLEMENTED BY THE NEW JERSEY STATE POLICE. THE RECORD ROOM STAFF WILL INSTRUCT EACH APPLICANT ON THIS NEW PROCEDURE.

PLEASE PRINT IN ENGLISH ONLY!

All questions must be answered truthfully, otherwise your application will not be accepted Falsification on this application will result in criminal prosecution under NJS 2C:28-3

NAME
Address
Name of Cab Company where you will work:
Address of Cab Company:
Previous addresses for the last five years
Date of Birth: Place of Birth: Height: Weight:
Age Eyes: Hair: Social Security#
New Jersey Drivers License Number:
Has your license ever been suspended or revoked: YES OR NO?
How long have you lived in Union City:
Married or Single:
Are you a citizen of the United States: YES OR NO?
If not what proof of eligibility to work in the U.S. do you show: ?

Have you ever been arrested or summoned to court on ANY charge in the state, or ANY state: YES OR NO
(If yes, give particulars and disposition of every case):

State of New Jersey)
City of Union City )
County of Hudson )

Being duty sworn, disposes and states that is the individual
Making the forgoing application for a taxicab operators license: that the answers to the forgoing questions and
Other statements contained therein set true of own knowledge and belief.

Notary Public State of New Jersey

Signed



# City Of Union City Department Of License Inspector



## REPORT OF PHYSICAL EXAMINATION

I have examined \_\_\_\_\_

Address: \_\_\_\_\_

In addition, make the following report: \_\_\_\_\_

Eye Sight: \_\_\_\_\_

Hearing: \_\_\_\_\_

Heart: \_\_\_\_\_

Are there any infirmities in body or mind which, in the judgment of the physician would render the applicant unfit to operate a taxicab? If any, Please give detailed information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personal description:

(a) Color \_\_\_\_\_

Physician \_\_\_\_\_

(b) Sex \_\_\_\_\_

Address \_\_\_\_\_

(c) Height \_\_\_\_\_

Telephone \_\_\_\_\_

(d) Weight \_\_\_\_\_

Date of Examination \_\_\_\_\_

(e) Color Eyes \_\_\_\_\_

(f) Color Hair \_\_\_\_\_

(g) Age \_\_\_\_\_

Date of photograph \_\_\_\_\_