

**CERTIFIED MOBILITY ASSISTANCE VEHICLE TECHNICIAN CERTIFICATION ROSTER
TO COUNTY SUPERINTENDENT**

County Name _____ | | | | Code _____ District/Private School _____ | | | | Code _____ | | | | Code _____ Contractor Name _____

	LAST NAME	FIRST NAME	TRAINING DATE	SS#	DOB	DRIVERS LICENSE NUMBER	EXPIRATION	CRIMINAL HISTORY APPROVAL
1	_____	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____	_____	_____	_____
11	_____	_____	_____	_____	_____	_____	_____	_____
12	_____	_____	_____	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____	_____	_____	_____
14	_____	_____	_____	_____	_____	_____	_____	_____
15	_____	_____	_____	_____	_____	_____	_____	_____
16	_____	_____	_____	_____	_____	_____	_____	_____
17	_____	_____	_____	_____	_____	_____	_____	_____
18	_____	_____	_____	_____	_____	_____	_____	_____
19	_____	_____	_____	_____	_____	_____	_____	_____
20	_____	_____	_____	_____	_____	_____	_____	_____