Date Received
By Clerk:_____

Fee Received:_____

Date Forwarded
To Police Dept:_____

Borough of Hightstown
156 Bank Street, Hightstown, NJ

Taxi Driver Application
January 1, 2025 – December 31, 2025

Driver's Name:_____

Instructions

This application must be filled out in full and signed by the applicant.

Please type or print clearly all information. Any false statement is sufficient cause for exclusion of the applicant from consideration of licensing.

Read each question carefully and answer all that is asked.

Your application will not be reviewed unless you provide all of the following information:

_____ Check or Money Order for $50

_____ Proof of fingerprinting. Appointments must be made on-line. See instructions attached.

_____ The recommendations of three reputable citizens

_____ Copy of valid New Jersey Driver's License

_____ Current certified Driver Abstract from the NJ Motor Vehicle Commission

_____ Proof of citizenship or legal resident status

_____ Completed Medical Examination Report for Taxicab/Limo/Medical Driver Fitness Determination Form (form attached) **This is the form that must be completed**.

The completed application must be signed in the presence of a notary public testifying that the statements on the application are true to the best of your knowledge.

Approval of all applicants is subject to review by the Borough of Hightstown Police Department.

There may be amendments to the current taxi ordinance that you will have to follow in order to keep your approved license.

Sign below to acknowledge that you have read and understand the above instructions.

_____
Signature of Applicant

The attached applicant has been fingerprinted and has been cleared with the New Jersey State Bureau of Identification. I have examined the foregoing application and find no police record.

_____
Police Department

DRIVER'S INFORMATION – Please type or print all information

Name:_____
Last First Middle

Address:_____
Street City State Zip

Home Phone:_____Cell Phone_____

Email address:_____

Date of Birth:_____Place of Birth_____

Sex: _____Height_____Weight_____Eye Color_____Hair Color_____

SS#_____Driver's License #_____

1. Has your driver's license and/or registration ever been suspended or revoked in this state or any other? Yes_____No____

   If yes, why? _____

   _____

   _____

2. Do you have any criminal charges of any sort, pending against you? Yes_____No_____

   If yes, why? _____

   _____

   _____

3. Have you ever been convicted of a crime? Yes_____No_____
4. Are you currently serving any sentence including probation? Yes _____No ____ If yes, for how long? _____
5. Do you currently suffer from any mental condition, physical impairment or sickness that may affect your ability to operate a motor vehicle safely? Yes _____No _____ If yes, what?

   _____

6. Have you ever been hospitalized, treated or observed by a doctor or psychiatrist for a mental condition? Yes _____No _____

7. Do you have a chemical or alcoholic dependency? Yes_____ No_____

8. If yes, are you currently being treated for your chemical or alcohol dependency? Yes___ No___

9. Do you presently own or have you ever owned your own company? Yes____ No_____ If yes,

   give company name, address and date _____

   _____

   _____

NOTICE TO ALL PERSONS SIGNING THIS FORM:

The Borough of Hightstown reserves the right to prosecute any false statement made on this form the fullest extent of the law against the signer(s).

Be on notice that any person who includes false statement in this form (whether by omitting requested information, or by including information that is false), and then signs the form, will be subject to punishment. Pursuant to N.J.S.A. 2C:28-3(a), it is a crime of the fourth degree to make a false written statement on this form which the signer does not believe to be true. Pursuant to N.J.S.A. 2C:28-2(a), it is a crime of the fourth degree to make a false statement under oath or equivalent affirmation.

By my signature below, I hereby swear and affirm that:

• I am at least twenty-one (21) years of age.

• I am (check one) a United States citizen _____ or a legal resident alien_____. *If a resident alien, a copy of the alien registration card or work permit must be submitted with this application*.

• I possess a current and valid New Jersey driver's license. *A copy of your NJ Driver's License must be submitted with this application.*

• I am not addicted to the use of narcotics or intoxicating liquors.

• I am able to read, speak and understand the English language.

• I have not been convicted of any crime involving moral turpitude.

• I have taken the time to study state and local motor vehicle laws, rules, and regulations. I have also made sure that I am fully informed of the geography of the Borough of Hightstown, Mercer County, and key locations (such as airports and train stations) in the State of New Jersey.

• I have not been convicted, within the three years prior to the date of the application, of reckless driving, driving while intoxicated, leaving the scene of an accident or driving more than 30 miles an hour above the speed limit.

• At the time of this application, I have no more than eight (8) New Jersey State Division of Motor Vehicle points on my driving record, or the equivalent if licensed in any other state.

I agree that I will inform the Borough of Hightstown in writing WITHIN THREE DAYS of any change in, or addition to, the information set forth above.

I am the applicant named above; that the questions are answered by me and that the statements of facts contained in the forgoing application are true to the best of my knowledge, information and belief.

_____

Signature of Applicant

State of New Jersey ss

County of _____

Subscribed before me on this _____ day of _____, 20___

_____

Notary Signature

My commission expires _____

Medical Examination form for Taxi Drivers

Form must be completed by driver and reviewed and signed by medical examiner.

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No** ○ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? ○ **Yes** ○ **No** ○ **Not Sure**
If "yes," please describe below.

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ **Yes** ○ **No** ○ **Not Sure**

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

DRIVER'S SIGNATURE

I certify that the above information is accurate and complete.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: ◯ Yes ◯ No Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

Other testing if indicated

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/_____	20/_____	Right Eye: _____ degrees
Left Eye:	20/_____	20/_____	Left Eye: _____ degrees
Both Eyes:	20/_____	20/_____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	◯	◯
Monocular vision	◯	◯
Referred to ophthalmologist or optometrist?	◯	◯
Received documentation from ophthalmologist or optometrist?	◯	◯

Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results Right Ear Left Ear

Record distance *(in feet)* from driver at which a forced whispered voice can first be heard _____ _____

OR

Audiometric Test Results

Right Ear:			Left Ear:		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	**Body System**	Normal	Abnormal
1. General	◯	◯	8. Abdomen	◯	◯
2. Skin	◯	◯	9. Genito-urinary system including hernias	◯	◯
3. Eyes	◯	◯	10. Back/spine	◯	◯
4. Ears	◯	◯	11. Extremities/joints	◯	◯
5. Mouth/throat	◯	◯	12. Neurological system including reflexes	◯	◯
6. Cardiovascular	◯	◯	13. Gait	◯	◯
7. Lungs/chest	◯	◯	14. Vascular system	◯	◯

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

CERTIFICATION STATUS

_____ Is qualified to drive a Taxicab

_____ Does not meet the standard to drive a taxicab

_____ Qualified only when wearing corrective lenses

_____ Qualified only when wearing a hearing aid

Medical Examiner's Signature_____

Medical Examiner's Name (printed)_____

Address_____

Telephone_____

Email_____

Date of Examination_____

FINGERPRINT INSTRUCTIONS

ALL Taxi Driver applicants are required to be fingerprinted, prior to submitting their Taxi Driver Application. **This applies to new and renewal taxi driver applicants**. Please utilize the attached IdentoGo New Jersey Universal Fingerprint Form for instructions. Fingerprinting is done by appointment only and scheduling can be done online at https://uenroll.identogo.com using service code: 2F17ZY or by calling 1-877-503-5981. While scheduling your fingerprinting appointment, you will be required to provide the Originating Agency Number (ORI#) for fingerprinting. The ORI# for Hightstown is NJ0110400.

Please Note - Taxi Driver Applicants are required to provide the attached fingerprinting form and IdentoGo fingerprinting receipt to show proof that the applicant was fingerprinted. If the Taxi Driver Application is not fully completed or if the applicant has not been fingerprinted, the application will **NOT** be accepted.

IdentoGO By IDEMIA

New Jersey Universal Fingerprint Form

https://uenroll.identogo.com/

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number	
NJ0110400	LOX	13.59-1	
(4) Reason for Fingerprinting		(5) Document Type	(6) Payment Information
LOCAL ORDINANCE		S1	
(7) Contributor's Case # (Unique Identifier)		(8) Miscellaneous	
TAXI			

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number ( ) -	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	

(20) Home Address

Address City State Zip

(21) Gender (Select one)	(22) Hair Color	(23) Eye Color	(24) Race (Select One)
[ ] Female [ ] Male [ ] Both			[A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown

(25) Occupation / Position (with respect to Requirement)	(26) Employer / Organization Name (with respect to Requirement) Employer Address City State Zip

Identification Requirement - *Acceptable Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria: Photo, Name, Address (home/Issuing agency) and Date of Birth. Acceptable ID must be issued by a Federal, State, County or Municipal entity for identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2011).

Please READ This Form Carefully:

Follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. ***PLEASE PRINT LEGIBLY****. It is* ***required*** *that you* ***present*** *this completed Universal Fingerprint Form,* IDG_NJAPP_051719_V1, *at your scheduled appointment.*

Appointment Scheduling:

Scheduling is available anytime at **https://uenroll.identogo.com/.** Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an applicant is responsible for payment, payment is required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, American Express, Discover and prepaid debit cards, or electronic debit (ACH) from a checking account. Accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $12.00 plus tax ($12.80) will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. Idemia Identity & Security will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment, inability to present proper identification, inability to present this completed Universal Fingerprint Form IDG_NJAPP_051719_V1, or the information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $12.00 plus tax ($12.80) appointment fee. Idemia Identity & Security will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting, you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. Idemia Identity & Security will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information:		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM