NORTHEASERN CLINTON CENTRAL SCHOOL
TRANSPORTATION REQUEST

This request must be submitted to the District Office each time special transportation is requested, **at least (15) working days before trip date**. The Transportation Department will not schedule transportation without the approvals indicated.

Date of Request: __________________
Phone Number:___________________
Building/Dept.:_________________
Person(s) requesting special transportation: ____________________________________
Group Transportation is for: ____________________________________________________
Trip to:______________________________________________________________________
Reason for trip:________________________________________________________________
Departure Date: __________________ Time:___________________
Pickup Point(s):____________________
Return Date: __________________ Time:___________________
Return Point:____________________
Estimated number of passengers: __________ (Students __________/Adults__________)

**Type of Vehicle Requested:**

_____6 passenger Van*  __________22 Passenger Bus
_____8 passenger Van*  __________66 Passenger Bus
______Wheelchair Lift Bus

*Vehicle can be driven by Occasional Driver

AUTHORIZATIONS: ___________________________________________Building Principal
________________________________________________________________________Superintendent

TRANSPORTATION DEPARTMENT USE ONLY:

Drivers Name: ____________________________ Bus #:_______ Date: __________
Event Type:________________________________________________________________
Departure Time: ___________ Return Time: ___________
Beginning Mileage ___________ Ending Mileage ___________ Total Mileage_____
Layover Start Time:__________ Layover End Time: ___________
Number of Passengers: ________ Signed: _______________________________________

REVISED 6/13/18