



TEMPORARY VEHICLE AGREEMENT

State Form 52297 (R4 / 7-23)
INDIANA DEPARTMENT OF HEALTH
ADMINISTRATIVE SERVICES

Date: _____
(month, day, year)

To: _____ Fleet Manager

Thru: _____ Program Manager
(Signature)

From: _____ Name of Driver *(first, last)*

Vehicle Scheduled: _____

Drivers Extension and Floor:

Drivers Destination:

Vehicle Pick-up Date *(month, day, year)* and Time: Vehicle Return Date *(month, day, year)* and Time:

Do you have a valid driver's license? Yes No

Do you have Auto Insurance? Yes No

Gas Card Received: Yes No

I do hereby certify that I will abide by the IDOH policies and requirements appropriate for this vehicle. I am aware that only I may drive the vehicle. Family members are not permitted in the vehicle, and non-state employees can travel in the vehicle only if on State business and they sign liability waivers. The vehicle may be used only for State business.

Drivers Signature