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United States Department of Transportation
Federal Motor Carrier Safety Administration

FMCSA Office of Information Management
 Annual Report of Class I Motor Carriers of Passengers

FORM MP-1

CALENDAR/FISCAL YEAR: _____

NAME OF MOTOR CARRIER: _____ **MC NUMBER:** _____

TRADE or DOING BUSINESS AS: _____ **USDOT NUMBER:** _____

ADDRESS: Street: _____ **City:** _____

State: _____ **Zip Code:** _____ - _____

TELEPHONE (include area code): _____

1. TYPE OF OPERATION based on major sources of revenue (check one): *Regular route service* *Charter service*

2. If respondent is a consolidated group, list and describe all entities making up the consolidation.

3. If a merger, consolidation, or change in the company or consolidated group occurred during the year, please describe.

(continued on next page)

	Respondent only	Consolidated
4. Number of Passengers:	(a) Intercity regular route	
	(b) Charter or special	
	(c) Local or commuter	
	(d) Total passengers	
5. Revenue:	(a) Intercity regular route	\$
	(b) Charter or special	\$
	(c) Local or commuter	\$
	(d) Express and other revenue	\$
	(e) Total operating revenue	\$
6. Total Operating Expenses	\$	\$
7. Net Operating Income (Loss)	\$	\$
8. Other Income (Deductions)	\$	\$
9. Extraordinary Items, Net of Taxes	\$	\$
10. Total Provision for Income Taxes	\$	\$
11. Net Income (Loss)	\$	\$
12. Total Assets	\$	\$
13. Total Liabilities	\$	\$
14. Shareholders' Equity	\$	\$
15. Operating Ratio		

CERTIFICATION: *I hereby certify that this report was prepared by me or under my supervision, that I have examined it, and that the items reported on the basis of my knowledge and belief are correctly shown.*

NAME (print or type)

TITLE

STREET ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE (include area code)

SIGNATURE

DATE

RETURN THE COMPLETED FORM TO:

Department of Transportation
Federal Motor Carrier Safety Administration
Office of Registration and Safety Information (MC-RS)
1200 New Jersey Avenue SE
Washington, DC 20590

Phone: (800) 832-5660
Fax: (202) 366-3477