

**OUT OF STATE LICENSE RENEWAL, DUPLICATES AND REPLACEMENTS,
PERMIT, CLASS O (Car), CLASS M (Motorcycle) DATA FORM**

NOTE: Duplicates and Replacements do not answer questions 5-7 or Section B Vision Test Results.

Review information and make any necessary changes.
*Your NEBRASKA address must appear on this form.

Date of Birth			Social Security Number*
Month	Day	Year	

LAST NAME		FIRST NAME			MIDDLE INITIAL	SUFFIX (JR, SR, 1ST, 2ND, 3RD)	
CURRENT RESIDENTIAL ADDRESS REQUIRED (Street address or Route and P.O. Box)				CITY	STATE	ZIP CODE	
CURRENT MAILING ADDRESS (If different from residential address)				CITY	STATE	ZIP CODE	
COUNTY NUMBER	GENDER	HEIGHT		WEIGHT	EYE COLOR	HAIR COLOR	RACE
		FT.	IN.				
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN OR PACIFIC ISL. <input type="checkbox"/> OTHER

For the purposes of complying with Neb.Rev.State.4-108 through 4-114, I attest: FAX # _____

I am a citizen of the United States..... OR _____ YES ___ NO

I am a qualified alien under the federal Immigration and Nationality Act and agree to provide a copy of my USCIS documentation upon request..... _____ YES ___ NO

A. Please answer the following questions.

- Do you wish to register to vote as part of this application process? (You only need to re-register if you have changed your name, address or political party.) _____ YES ___ NO
- Do you wish to be an organ and tissue donor? _____ YES ___ NO
- Do you wish to receive any additional specific information regarding organ and tissue donation? _____ YES ___ NO
- Do you wish to donate \$1 to promote the Organ and Tissue Donor Awareness and Education Fund? _____ YES ___ NO
- Have you within the last three months (e.g. due to diabetes, epilepsy, mental illness, head injury, stroke, heart condition, neurological disease, etc.):
 - lost voluntary control or consciousness (date: _____) _____ YES ___ NO
 - experienced vertigo or multiple episodes of dizziness or fainting _____ YES ___ NO
 - disorientation _____ YES ___ NO
 - seizures (date: _____) _____ YES ___ NO
 - impairment of memory, memory loss _____ YES ___ NO
- Do you experience any condition which affects your ability to operate a motor vehicle due to loss or impairment of:
 - foot/leg _____ YES ___ NO
 - upper body strength _____ YES ___ NO
 - range of motion/mobility _____ YES ___ NO
 - hand/arm _____ YES ___ NO
 - neurological/neuromuscular disease _____ YES ___ NO
- Since the issuance of your last license/permit, has your health or medical condition worsened? _____ YES ___ NO

**B. VISION TEST RESULTS: To be completed by Optometrist/Ophthalmologist/ or Out of State Driver License Examiner.
NOTE - Vision test results not valid after 90 days from Examination Date.**

Glasses or Contacts? ___ Yes ___ No Acuity: Right Eye _____ Left Eye _____ Both _____
*Peripheral Vision: Right _____ Left _____ Both _____
***(Peripheral reading in degrees for each eye is required by Nebraska State Law)**

I certify that the person named hereon has established his/her identity and completed the requested vision test with the results indicated above.

Signature of Optometrist / Ophthalmologist / Out of State License Examiner _____ Date of Exam _____

State _____ Phone Number: _____