NEBRASKA DEPARTMENT OF MOTOR VEHICLES
OUT OF STATE LICENSE RENEWAL DATA FORM

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 FT.	HEIGHT IN.	WEIGHT	EYE COLOR	HAIR COLOR	RACE
	☐M ☐F						☐ BLACK ☐ AMERICAN INDIAN ☐ HISPANIC ☐ WHITE ☐ ASIAN OR PACIFIC ISL. ☐ 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..... ____YES ____NO

OR

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.

1. 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
2. Do you wish to be an organ and tissue donor? ____YES ____NO
3. Do you wish to receive any additional specific information regarding organ and tissue donation? ____YES ____NO
4. Do you wish to donate $1 to promote the Organ and Tissue Donor Awareness and Education Fund? ____YES ____NO
5. Have you within the last three months (e.g. due to diabetes, epilepsy, mental illness, head injury, stroke, heart condition, neurological disease, etc.):
   - A. lost voluntary control or consciousness (date: _____) ____YES ____NO
   - B. experienced vertigo or multiple episodes of dizziness or fainting ____YES ____NO
   - C. disorientation ____YES ____NO
   - D. seizures (date: _____) ____YES ____NO
   - E. impairment of memory, memory loss ____YES ____NO
6. Do you experience any condition which affects your ability to operate a motor vehicle due to loss or impairment of:
   - A. foot/leg ____YES ____NO
   - B. upper body strength ____YES ____NO
   - C. range of motion/mobility ____YES ____NO
   - D. hand/arm ____YES ____NO
   - E. neurological/neuromuscular disease ____YES ____NO
7. 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:** _____

TSIRDT 10/09