СОМ	PLETE INFO	ORMATIO	N BELOW	- PLEASE PRINT	Month	Day	Year		<u>u. 000u.</u>	<u>.</u>	
LAST N	AME			FIRST NAME				MIDDLE II	NITIAL	SUF	FIX
CURRENT RESIDENTIAL ADDRESS REQUIRED (Street address or Route <u>and</u> P.O. Box)						CITY			STATE	ZIP (	CODE
CURRENT MAILING ADDRESS (If different from residential address)						CITY				ZIP (	CODE
COUNTY HEIGHT WEIGHT					EYE HAIR COLOR COLOR RA				RACE		
NUMBE	ER GENDER	FT.	IN.	WEIGHT	COLOR	COLOR	BLAC		RICAN INDIA	N [	OTHER
For t	the purposes o	f complying	with Neb. I	 	test:		WHIT	E ASIA	N OR PACIF	IC ISL.	HISPANIC
				OR		• • • • • • • • • • • • • • • • • • • •			Yes	_	No
				ut do have lawful status					_Yes	_]	No
Plea	ase answer qu	estions A1 <u>A</u>	<u>ND</u> A2.								
	representative I certify that revoked or ca	of the class I am not su ncelled in thi	of commerce bject to any s or any other	motor vehicle in which ial motor vehicle that I op disqualification under a er State and that I do not	perate or exp 383.51, that have a drive	ect to oper my licenser's license	ate e is not su from more	ispended, than one	Y		No
Choo	ose <u>one</u> of the	following cat	tegories tha	t apply to you (use char	t to assist yo	ou in choos	sing corre	ct categor	·y).		
A.	<u>Interstate – Non-Excepted:</u> Subject to federal medical/vision requirements - must provide DMV with current medical examiner's certificate (card – NOT long form) and keep current with DMV								`	Yes	No
B.	<u>Interstate – Excepted:</u> Subject to DMV medical/vision requirements – answer questions #5-#7 below.									Yes	No
C.	<u>Intrastate – Non-Excepted:</u> Subject to federal medical/vision requirements – <b>NOT</b> required to provide DMV with current medical examiner's certificate.									Yes	_No
D.	Intrastate – I			IV medical/vision require	ments – ans	wer questio	ons #5-#7		<b>Y</b>	/es	No
Ans	wer question A	A3 <u>OR</u> A4.		7					_		_
A3.	-			commercial or non-comm		-			Y	<b>a</b> c	No
A4.	years							Y		No	
	Please list Sta Please list any	ite(s): other names	you were k	nown as while holding th	ose license(	s):					
<b>I</b>			,		,						<del></del>
				eteran designation/orga				•	are opti	onal)	).
	have changed Do you wish to	your name, on have the wo	<i>address or p</i> ord "Veterar	rt of this application procolitical party) "displayed on the front of the control of the co	of your lice	nse to show	that you s	erved in t		Yes	No
2.	Veterans' Aff	airs Registry	)	donor?				-	— <sub>7</sub>		No
3.	•	_		specific information rega							No No
4.	-	_		he Organ and Tissue Don							No
				estions if you answered ered "Yes" to questions			or D abov	e. <u>DO N</u> 0	<u>TO</u>		
5.	A. lost vo B. experi C. disorio D. seizur	on, neurological pluntary control cont	cal disease, rol or consci	s (e.g. due to diabetes, epetc.): ousness (date: e episodes of dizziness or  y loss	fainting	)			·	Yes Yes Yes	No No No No No
6.	Do you experimpairment of A. foot/le B. upper C. range D. hand/a	rience any cof:  body strengtlof motion/moarm	ondition wh	ich affects your ability t	to operate a	motor vel	nicle due t	o loss or	·	Yes Yes Yes Yes	NoNoNoNo
7.	Since the issu	ance of your	last license/	permit, has your health or	r medical co	ndition wo	rsened?		-	Yes	No

\_\_Yes \_\_No