

## OHIO DEPARTMENT OF PUBLIC SAFETY BUREAU OF MOTOR VEHICLES

## NEXT OF KIN / EMERGENCY CONTACT ENROLLMENT

To register, please visit our Web site at <a href="www.bmv.ohio.gov">www.bmv.ohio.gov</a> or complete this form and return it to your local Deputy Registrar or mail it to:

OHIO BUREAU OF MOTOR VEHICLES
Attn: Verification Services
Document Management
P.O. Box 16520
Columbus, Ohio 43216-6520

NOTE: If this form is not filled out completely, Next of Kin information will not be updated nor will this form be returned for correction. Any changes to this document will override any previous submissions to add or change the Next of Kin Notification information. (Please ensure the accuracy of any next of kin information provided and ensure that this information is updated as applicable; the BMV is not responsible for any errors in information provided or for failure to provide updated information. Pursuant to Ohio Revised Code [R.C.] section 4501.81, the BMV will not be liable if contact cannot be made with a designated contact person in the event of an emergency).

Yes, I want to add Next of Kin / Emergency Contact information to my Ohio Driver License or Identification Card record.  Please remove all Next of Kin / Emergency Contact information listed on my Ohio Driver License or Identification Card record (disregard section 3)  Please change the Next of Kin / Emergency Contact information on my Ohio Driver License or Identification Card record to the following.  2. OHIO DRIVER LICENSE / IDENTIFICATION CARD HOLDER INFORMATION (Required)  OHIO APPLICANT LAST NAME  ADDRESS  CITY  STATE  ZIP CODE  OHIO DRIVER LICENSE # or IDENTIFICATION CARD # (Information Required)  3. NEXT OF KIN / EMERGENCY CONTACT INFORMATION Need one contact person's phone number OR address to process.  CONTACT #1  AST NAME  FIRST NAME  FIRST NAME  MI  RELATIONSHIP  HOME PHONE  CELL PHONE  CITY  STATE  CODE  Checking this box means that this person has accurate, detailed and up to date medical information about me that may be shared with any medical professionals providing emergency medical treatment to me.  CONTACT #2  LAST NAME  FIRST NAME  MI  RELATIONSHIP  HOME PHONE  CELL PHONE  CELL PHONE  CONTACT #2  Checking this box means that this person has accurate, detailed and up to date medical information about me that may be shared with any medical professionals providing emergency medical treatment to me.  CONTACT #2  Checking this box means that this person has accurate, detailed and up to date medical information about me that may be shared with any medical professionals providing emergency medical treatment to me.  Checking this box means that this person has accurate, detailed and up to date medical information about me that may be shared with any medical professionals providing emergency medical treatment to me.  Checking this box means that this person has accurate, detailed and up to date medical information about me that may be shared with any medical professionals providing emergency medical treatment to me.  Checking this box means that this person has accurate, detailed and up to date medica	1. PLEASE CHECK ONE OF THE FOLLOWING			
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