OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

NEXT OF KIN / EMERGENCY CONTACT ENROLLMENT

To register, please visit our Web site at www.bmv.ohio.gov **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).**

1. PLEASE CHECK ONE OF THE FOLLOWING

- ☐ 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	FIRST NAME		MI
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	LAST NAME	FIRST NAME		MI
RELATIONSHIP	HOME PHONE ( )	CELL PHONE ( )	WORK PHONE ( )	EXT.
ADDRESS		CITY	STATE	ZIP 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 ( )	WORK PHONE ( )	EXT.
ADDRESS		CITY	STATE	ZIP 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.**

4. SIGNATURE OF OHIO DRIVER LICENSE / IDENTIFICATION CARD HOLDER *(Required)*

I understand by checking the box and providing contact information for an individual with knowledge of my medical history, I am authorizing law enforcement to release my contact person's information to first responders and medical professionals.

SIGNATURE	DATE
X	

RESTRICTED-PII