

# DMV PROCEDURAL BULLETIN

## NEBRASKA MEDICAL HARDSHIP DRIVING PERMIT

### **WHAT IS THE MEDICAL HARDSHIP PERMIT?**

Nebraska State Statute 60-4,130.01 authorized this permit, and it allows a Medical Hardship Driving Permit for individuals who have forfeited their regular driving privileges under the Point System. The Medical Hardship Permit would be valid for 90 days, at the expiration of the permit, the driver may reapply for another permit in the same manner.

This permit can be used to drive from home or place of employment to a hospital, clinic, doctor's office, or similar location and return. It cannot be used for shopping, probationary meetings or school.

The issuance of such permit is based upon meeting all appropriate requirements and certification that the use of the vehicle is required as part of one's medical hardship and there is no reasonable alternative means of transportation.

### **WHO IS ELIGIBLE?**

**ONLY THOSE INDIVIDUALS WHOSE DRIVING PRIVILEGES HAVE BEEN REVOKED UNDER THE POINT SYSTEM ARE ELIGIBLE.** An individual, who is eligible to be reinstated on any prior suspension/revocation, must be reinstated on that suspension/revocation in order to be eligible for a Medical Hardship Driving Permit.

### **WHAT ARE THE REQUIREMENTS?**

- (1) An Application for Nebraska Medical Hardship Permit (the application can be downloaded from the Department of Motor Vehicles website <http://www.dmv.ne.gov> or can be mailed to the driver upon request. A separate application must be completed for each physician.
- (2) Contents of such application form will include: a) General application statement; b) physician affidavit, a complete affidavit describing the necessity and details of such need; d) an affidavit certifying no alternative means of transportation.
- (3) The application form must be submitted for evaluation and review. In addition, we must receive the revoked Nebraska Operator's License (if not already surrendered).
- (4) Proof of financial responsibility may be given by one of the following: a) By filing with the Department of Motor Vehicles, a written certificate of insurance from any insurance company duly authorized to do business in the State of Nebraska, certifying that there is in effect a motor vehicle liability policy for the benefit of the person required to furnish the proof of financial responsibility. The certificate of insurance is identified by form SR-22. We are not permitted to accept your policy or a binder as being the proper identification of your proof of financial responsibility. b) A Bond of a Surety Company duly authorized to transact business within the State of Nebraska or a bond with at least two individual sureties who each own real estate within the State of Nebraska which real estate shall be scheduled in the bond approved by a Judge or a court of record. This said bond shall be conditioned for the payment of the amounts specified in sub-section 10 in Section 60-501 (\$75,000.00). c) A Cash bond in the amount of \$75,000.00 furnished by a certified check or money order.

**THE DIRECTOR OF THE DEPARTMENT OF MOTOR VEHICLES WILL REVOKE THE MEDICAL HARDSHIP DRIVING PERMIT OF ANY DRIVER CONVICTED OF A VIOLATION FOR WHICH POINTS ARE ASSESSED.** If the permit is revoked in this manner, the individual will not be eligible to receive a Medical Hardship Driving Permit for the remainder of the period of revocation.

### **WHERE DO I APPLY AND HOW LONG WILL IT TAKE?**

Send requirements to the Department of Motor Vehicles, Medical Hardship Driving Permit Program, P.O. Box 94877, Lincoln, NE 68509-4877. The Department must meet all statutory requirements in review and evaluation of the application. If requirements are met, the Medical Hardship Drive Permit Authorization letter will be issued for the driver to present to the Driver License Examiner.



## Financial Responsibility Division

Medical Hardship Driving Permit Program  
 301 Centennial Mall South, P.O. Box 94877  
 Lincoln, Nebraska 68509-4877  
 (402) 471-3985 Fax (402) 471-8288

### APPLICATION FOR NEBRASKA MEDICAL HARDSHIP PERMIT – POINT REVOCATION

**1** Items A – E below must be completed and sent to the Financial Responsibility Division at the address listed above. If the application is properly completed and you are eligible, you will be sent a letter authorizing you to go to a Driver Examining Station to be issued the Medical Hardship Driving Permit.

- A. Must be a Nebraska resident, have tested and been issued a license (Provisional Operator’s Permit holders are not eligible for the Medical Hardship Drive Permit).
- B. Current **Nebraska Operator’s License** – if not already surrendered;
- C. Properly completed **SR-22 Certificate of Insurance** from your insurance company (application, binder or insurance card will not be accepted);
- D. **This completed application form. You will need a separate application for each doctor you have; and,**
- E. Comply with all reinstatement requirements for any suspensions/revocations in Nebraska or any other state that prohibits you from obtaining the Medical Hardship Drive Permit.

**NOTE:** The Authorization Letter for Issuance of Medical Hardship Drive Permit is based upon you, the driver, meeting all conditions. If any of the above requirements are not met, you will not be issued the Authorization Letter.

### 2 Provide Personal Information (Please Print)

Last Name		First Name		Middle Initial	Suffix (Jr., Sr., 2 <sup>nd</sup> , 3 <sup>rd</sup> )
Current Residential Address (Cannot accept a mailing address or P.O. Box)			City	State	Zip Code
<b>Date of Birth</b>		<b>Home Phone Number</b>		<b>Social Security Number</b>	
Month	Day	Year			

**Providing you are eligible, upon receipt of all applicable requirements, you will be sent a letter authorizing you to appear before a Driver License Examiner to obtain the Nebraska Medical Hardship Drive Permit. Authorization is based on meeting all conditions including certification that the use of a vehicle is a requirement for your medical treatment and there is no reasonable alternative means of transportation. The Medical Hardship Drive Permit is valid for 90 days and you must apply for renewal if still needed after the expiration date.**

### By signing this application I swear or affirm that:

**3** I certify that I will notify the Department of Motor Vehicles of change or termination of treatment. If I change treatment, I must immediately contact the Department of Motor Vehicles to file a revised application in reference to my new treatment schedule in order to maintain my Medical Hardship Drive Permit privileges. I understand that my permit will not be valid until there is a properly completed application on file for my treatment.

**Please initial** **By initialing this statement, I agree and understand that failure to notify the Department of any change in my treatment will cause my Medical Hardship Driving Permit to immediately become null and void.**

**4** I understand that the Director of the Department of Motor Vehicles will revoke the Medical Hardship Drive Permit upon receipt of the abstract of conviction indicating that I committed an offense for which points are assessed and I will not be eligible to receive a Medical Hardship Drive Permit for the remainder of the period of revocation of my operator’s license or privilege to drive.

**Please initial** **By initialing this statement, I understand that if I commit any violation where points are assessed my Medical Hardship Driving Permit will be revoked.**

5

**Medical Information:**

Place of treatment:

Describe the nature of your medical treatment:

6

**Days/Hours – detailed information is required for your protection. If you are stopped driving after the permit has been issued, law enforcement will refer to the application you submitted for verification of the days/hours of your treatment.**

Days of treatment (please  days required):

MON	<input checked="" type="checkbox"/>	TUE	<input checked="" type="checkbox"/>	WED	<input checked="" type="checkbox"/>	THUR	<input checked="" type="checkbox"/>	FRI	<input checked="" type="checkbox"/>	SAT	<input checked="" type="checkbox"/>	SUN	<input checked="" type="checkbox"/>
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Hours of scheduled treatment. Please include driving time:

Leave home at:		am	pm
Return home at:		am	pm

7

**Routes/Areas of travel - detailed information is required for your protection. If you are stopped driving after the permit has been issued, law enforcement will refer to the application you submitted for verification of your Routes/Areas of travel.**

Briefly describe other transportation options available:

Bus Routes:	
Other:	

**You must sign this application in the presence of a Notary Public:**

8

\_\_\_\_\_

**Applicant's Signature**

\_\_\_\_\_

**Printed name**

**Date:** \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

The signature of the Applicant was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**Notary Public Signature**

**Seal**

## Physician's Affidavit

Your patient is making application for a Nebraska Medical Hardship Drive Permit. State law requires, as one of the conditions for issuance for such permit, that the physician sign an affidavit swearing to the validity of the claim that the use of a vehicle is required in traveling to and from his or her place of treatment and/or in the course of the applicant's medical needs.

Your assistance is appreciated.

Patient's (Applicant's) Name:

Patient's (Applicant's) Address:

Street Address

City / State / Zip Code

## Medical Facility information

Name of the Medical Facility:

Facility Address:

Street Address

City / State / Zip Code

Physician's Name / Phone number:

Name

Phone Number

## I can confirm the need for my patient to drive as a condition of his/her medical needs as described below:

1.	I can confirm the need for my patient to drive as a condition of his/her medical needs.	<b>Please circle</b>	
		Yes	No
2.	I can confirm that treatment will not impair the applicant's ability to operate a motor vehicle.	<b>Please circle</b>	
		Yes	No
3.	The days/hours of travel my patient listed in Section 6 are correct.	<b>Please circle</b>	
		Yes	No
4.	The routes/areas of travel my patient listed in Section 7 are correct.	<b>Please circle</b>	
		Yes	No

## You must sign the application in the presence of a Notary Public:

<div data-bbox="121 1234 151 1260" data-label="Page-Header">12</div>	<p>Signature below must be same as Physician's Name provided in Section 10 above.</p> <p>_____</p> <p style="text-align: center;"><b>Physician's Signature</b></p> <p>_____</p> <p style="text-align: center;"><b>Printed name</b></p> <p><b>Date:</b> _____</p>	<p>State of _____</p> <p>County of _____</p> <p>The signature of the Physician was acknowledged before me this _____ day of _____, _____.</p> <p>_____</p> <p style="text-align: center;"><b>Notary Public Signature</b></p> <p><b>Seal</b></p>
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### NOTE:

The Medical Hardship Drive Permit cannot be used to operate a commercial motor vehicle or as a commercial driver's license.