WASHINGTON DEPARTMENT OF FISH AND WILDLIFE

HUNTER/FISHER WITH A DISABILITY APPLICATION

Mail to WDFW, Licensing Division, 600 Capitol Way N, Olympia, WA 98501-1091,
Fax to (360) 902-2945

Please Print Clearly

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SUFFIX JR / SR
MAILING ADDRESS	PHYSICAL STREET ADDRESS		

CITY	STATE	ZIP	PHONE ( )

SEX M / F	HEIGHT FT. IN.	WEIGHT	DOB	EYE COLOR	SSN __ __

WILD ID# E-Mail:

PERSONS ELIGIBLE FOR A DISABLED HUNTER PERMIT AND/OR A DESIGNATED HARVESTER CARD

(REDUCED FEES DO NOT APPLY)

Please select the privileges you are applying for: ☐ **Fishing** ☐ **Hunting**

☐ **Permanent physical disability**
[Copy of WAC 220-55-065 and 232-12-828 included). **Must provide Physicians certification below.**

Physician: must check one or more of the following boxes and initial.

_____ ☐ Upper extremity impairment (UE)
_____ ☐ Lower extremity impairment (mobility) (LE)
_____ ☐ Blind/Visually Impaired (BV)

REDUCED FEE HUNTING AND/OR FISHING AND SHELLFISH/SEAWEED LICENSES

☐ **Resident veterans** with at least 30% service connected disability as verified by VA letter
[Copy of RCW 77.32.480 available with application.]

☐ **Resident veterans 65 years of age or older** with a service connected disability as verified by VA letter
[Copy of RCW 77.32.480 available with application.]

♣ ☐ **Resident who permanently uses a wheelchair**, as certified by the doctor's signature below
[Copy of RCW 77.32.780 available with application]

♣ ☐ **Resident who is blind or visually impaired**. Central visual acuity does not exceed 20/200 in the better eye with corrective lenses or visual field is not greater than 20 degrees per physician's signature below [Copy of RCW 77.32.480 available with application]

♣ ☐ **Resident with a developmental disability** as determined by DSHS Authority or Physicians Certification below
[Copy of RCW 71A.10.020 available with application]

♣ = *Reduced fee qualifications that automatically receive a harvester card*

I hereby certify under penalty of perjury under the laws of the state of Washington that the foregoing information is true and correct.

*X*_____
Applicant's Signature Date

I am a physician for the above named person and by my signature do certify under penalty of perjury of law that he/she is as indicated
.

Physician's Signature Date

Address: Phone No

City State Zip

Physician's Medical ID#

(Mandatory)

WDFW USE ONLY

Approved By: Date: