SPECIAL USE PERMIT APPLICATION

for persons with disabilities

Washington Department of Fish and Wildlife

WASHINGTON DEPARTMENT OF FISH AND WILDLIFE

SPECIAL USE PERMIT APPLICATION

Mail to: WDFW, ADA Manager, PO Box 43139, Olympia, WA 98504
Fax to: (360) 902-2392

Please Print Clearly

APPLICANT INFORMATION REQUIRED

LAST NAME	FIRST NAME	MIDDLE	SUFFIX JR / SR
MAILING ADDRESS	PHYSICAL ADDRESS		

CITY	STATE	ZIP	CITY	STATE	ZIP

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

WILD ID	EMAIL	PHONE

I hereby certify under penalty of perjury under the laws of the State of Washington that the information provided on this form is true and correct. RCW 77.15.650(1)(a) Penalty Providing False Information

Applicant's Signature _____ *Date* _____

APPLICANTS CERTIFICATION OF DISABILITY

Applicant: You are applying for a Special Use Permit to accommodate your disability in hunting, fishing, or wildlife viewing activities. **State law restricts such permit to persons with permanent inoperable disabilities**. There are no temporary permits. Special Use Permits (SUP) are available to any person who has applied for, receives, and maintains in good standing "Disability Status" with Washington State Department of Fish and Wildlife (WDFW); and who has a permanent inoperable physical or cognitive disability; and the disability must be certified by a licensed physician through this SUP application process.

Application instructions:

1. **Applicant must complete and certify all information requested on page one (1).**
2. **Take application to licensed physician with intimate knowledge of your disability condition and physical impairment.**
3. **Review this entire packet with your physician.**
4. **Physician must review page 1 and complete page 2, 3, and 4.**
5. **Physician statements, signatures, address, phone, medical ID number and title are mandatory on this form.**
6. **Attach any supporting documentation to this application and mail or fax to the location/number provided above.**
7. **Allow 4-6 weeks for processing. Incomplete applications will be returned.**

Applicant: Please describe in very specific detail your medical condition and why you are requesting a Special Use Permit.

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PHYSICIANS MEDICAL CERTIFICATION OF APPLICANTS DISABILITY

Physician: The above applicant is applying for a Special Use Permit for accommodation in hunting, fishing, or wildlife viewing activities. **State law restricts such permit to persons with permanent inoperable disabilities**. There are no temporary permits. Correctable and operable disability impairments resulting from a diagnosed disease, disorder, and injury do not qualify.

WDFW is dedicated to improving opportunities for people with permanent disabilities through reasonable accommodations or equipment modifications. People with permanent inoperable disabilities may have unique needs due to their impairments. Special Use Permits (SUP) allow a specific exception to a recreational activity, service, or regulation. Each Special Use Permit is customized on a case by case basis to the individual's particular needs. WAC 232-12-819

Special Use Permits (SUP) are available to any person who has applied for, receives, and maintains in good standing "Disability Status" with Washington State Department of Fish and Wildlife (WDFW); and who has a permanent inoperable physical or cognitive disability; and the disability must be certified by a licensed physician through this SUP application process.

Application instructions:

1. Licensed MD, ARNP, PA with intimate knowledge of applicant's disability and physical impairment may complete application.
2. Review this entire packet with your patient.
3. Physician must complete and certify all information requested on page 2, 3, and 4.
4. Physician statements, signatures, address, phone, medical NPI number and title are mandatory on this form.
5. Attach any supporting documentation, testing protocol, or SOAP reports to this application.
6. Incomplete, vague, or illegible statements will be returned.

Physician must complete and certify the following information requested.

Physician, the following questions pertain specifically to the applicants permanent inoperable disability which renders them unable to hunt, fish, or view wildlife. **Physician initials required next to applicable answer and is subject to RCW 9A.72.030.**

1. Is the applicant's diagnosed disease, disorder, or injury disability permanent? YES ___Initial___ NO ___Initial___

   Indicate diagnosed disease, disorder, or injury: _____

2. Is the applicant's impairment from the disability condition permanent? YES ___Initial___ NO ___Initial___

   Indicate impairment resulting from disability: _____

3. Is the applicant's permanent disability: *Cognitive* ___Initial___ and /or *Physical* ___Initial___

4. Is the applicant's physical impairment correctable? YES ___Initial___ NO ___Initial___

5. Has applicant undergone surgery or other treatment to correct impairment? YES ___Initial___ NO ___Initial___

   List surgery date(s) applicable to impairment: _____, _____, _____, _____

   Indicate surgery or treatment type: _____

6. Is the applicant's permanent physical impairment 12 months post operative? YES ___Initial___ NO ___Initial___

7. If NO, do you recommend surgery to make whole the physical impairment? YES ___Initial___ NO ___Initial___

8. If surgery is not recommended, **explain in detail why** the physical impairment is considered permanent and not correctable:

   _____

   _____

   _____

   _____

Physician must complete and certify the following information requested.

Physician: This section identifies the applicable physical limits of function experienced today. Measurements scored during the evaluation and permanent impairment ratings test will be required below to substantiate the physical impairment. Only complete those that apply to the patients inoperable disability impairment. **Physicians initials are required for each applicable answer.**

9. Date physical limits of function measurements were scored? _____ Initial _____

10. If testing date exceeds two years, do the scores represent todays function limits? YES _____ Initial NO _____ Initial

11. Push impairment score: _____ Right Left Physical location: _____ Initial _____

12. Pull impairment score: _____ Right Left Physical location: _____ Initial _____

13. Lift impairment score: _____ Right Left Physical location: _____ Initial _____

14. ROM impairment score: _____ Right Left Physical location: _____ Initial _____

15. Grip strength score: _____ Right Left Physical location: _____ Initial _____

16. Muscle strength score: _____ Right Left Physical location: _____ Initial _____

17. Extremity - loss of function: Right Left Location: _____ _____ Initial _____

18. Amputation? Location: _____ Initial _____

19. Spinal Cord Injury? Location: _____ Initial _____

20. If impairment relates to mobility, indicate distance applicant can walk without the use of an assistive device?

0 - 50' _____ 51' - 100' _____ 101' - 200' _____ 200' - 500' _____

21. If impairment relates to mobility, indicate distance applicant can walk with the use of an assistive device?

0 - 50' _____ 51' - 100' _____ 101' - 200' _____ 200' - 500' _____

22. Applicant permanently uses a **medically prescribed** assistive device? YES _____ Initial NO _____ Initial

Example: walker, arm crutches, leg braces, oxygen, defibrillator? _____

23. Applicant permanently uses a prosthetic? Right Left Location: _____ YES _____ Initial NO _____ Initial

24. Applicant Permanently uses a Wheelchair? YES _____ Initial NO _____ Initial

25. Is applicant visually impaired? Acuity Rating: _____ YES _____ Initial NO _____ Initial

26. Indicate applicants inoperable visual diagnosed disease, disorder, or injury: _____

27. Has applicant been issued a parking placard under RCW 46.19.010(1)? YES _____ Initial NO _____ Initial

28. Has applicant been placed on Labor and Industries claim (L&I)? YES _____ Initial NO _____ Initial

29. Has applicant been placed on Disability Retirement (SSI)? YES _____ Initial NO _____ Initial

Physician must complete and certify the following information requested.

Physician: This section identifies permanent inoperable cognitive intellectual disabilities and impairments. Only complete those that apply to the applicants inoperable cognitive disability. **Physicians initials are required for each applicable answer.**

30. Did the applicants cognitive disability originate at birth? YES Initial NO Initial

31. Did the applicants cognitive disability originate from birth up to age 17 years? YES Initial NO Initial

32. Did the applicants cognitive disability originate from age 18 years to present? YES Initial NO Initial

33. Does applicant need an assistant to partake in hunting and fishing activities? YES Initial NO Initial

34. Cognitive aptitude (GAF): 0 - 30 _____ 30 - 55 _____ 55 - 75 _____ above 75 _____

35. Does the applicants intellectual function and adaptive behavior provide the skills necessary for safe firearm operation?

YES _____ NO _____ NEVER _____ OTHER _____

36. Describe in detail any additional cognitive information or intellectual diagnosis helpful for the applicants accommodation.

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Physician's Written Statement

Describe in detail how the applicants inoperable impairment permanently renders them unable to participate in a hunting, fishing or wildlife viewing activity in Washington State. Detail the medical history, determinations made, treatments, surgeries and prognosis establishing unequivocal evidence for this certification. Declare type of accommodation, equipment modification, access, or specific exception to a recreational activity, service, or regulation necessary for the applicants particular needs.

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Signature _____ Date _____

PHYSICIAN MEDICAL INFORMATION AND SIGNATURE CERTIFICATION

I _____ *Print Physician's Name* *am a licensed MD, ARNP, or PA for the above named person, and by my signature do certify under penalty of perjury according to the laws of the State of Washington RCW 9A.72.030, the above applicant has a permanent inoperable disability as I have indicated and verify the physical condition is serious enough to render them unable to hunt or fish without this permit. I understand physical conditions relating completely to the comfort level of the applicant are not acceptable criteria for the issuance of a Special Use Permit. Therefore, I confirm the information I have provided on this form is correct and true.*

Medical Signature _____ ***Date*** _____

Address _____

_____

_____ ***Phone*** _____

Medical License Number (NPI) _____ ***Title*** _____

Please have your licensed MD, ARNP, or PA sign to certify the permanent disability information.

WDFW use below

☐ APPROVED ☐ NOT APPROVED

Requested accommodation _____

Requirements: _____

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Processed by: _____

Title: _____

Date: _____

Received Date Stamp