



APPLICATION FOR A DISABLED HUNTER PERMIT

FOR OFFICE USE ONLYPermit #:
Date Issued:
Issued By:

 Last Name First Name Middle Initial Date of Birth (MM/DD/YYYY) XXX-XX-_____
 Social Security Number (Last 4 digits REQUIRED)

 Mailing Address City State Zip Code Daytime Phone Number

 Physical Address City State Zip Code Email Address (optional)

Weight (lbs)_____
Height (Ft' Inches")_____
Eye Color_____
Hair Color_____
Sex

I HEREBY SWEAR, UNDER PENALTY OF PROSECUTION, I AM PERMANENTLY DISABLED AS DESCRIBED IN THIS APPLICATION.

Applicant's Signature and Date

or

Parent/Legal Guardian's Signature and Date
(If applicant is under the age of 18)**IF APPLICANT IS APPLYING AS A DISABLED VETERAN, APPLICANT MUST COMPLETE:**

Has written proof that the last official certification of record by the United States Department of Veterans Affairs or any branch of the Armed Forces of the United States shows the person to be at least sixty-five (65%) percent physically disabled. Valid documentation (official Department of Veterans Affairs or official Armed Forces logo must be present in the document's letterhead) must be attached to this application to be considered complete.

IF APPLICANT IS NOT APPLYING AS A DISABLED VETERAN, PHYSICIAN MUST COMPLETE:

I, the undersigned, swear that I am a licensed medical doctor, nurse practitioner, physician's assistant, optometrist or ophthalmologist and find the above named applicant to be disabled as defined by one or more of the following condition(s): **THIS PORTION OF THE APPLICATION CANNOT BE ALTERED. ALTERED APPLICATIONS WILL NOT BE ACCEPTED.**

PLEASE CHECK THE APPROPRIATE BOX(ES):

Is permanently unable to walk **AT ALL TIMES** without the use of, or assistance from, a wheelchair, scooter, or walker;

Is restricted by lung disease to the extent the person's forced expiratory volume for one (1) second, when measured by a spirometer, is less than thirty-five (35) percent predicted, or arterial oxygen tension is less than fifty-five (55) mm/Hg on room air at rest;

Has a cardiac condition to the extent the person's functional limitations are classified in severity as Class III or Class IV, according to standards established by the American Heart Association;

Has a permanent, physical impairment that prevents the person **AT ALL TIMES** from holding or shooting a firearm or bow in hand;

Has central visual acuity that permanently does not exceed 20/200 in the better eye with corrective lenses, or the widest diameter of the visual field is not greater than twenty (20) degrees.

Name of Licensed medical doctor, nurse practitioner, physician's assistant, optometrist or ophthalmologist (PLEASE PRINT)_____
Address_____
City_____
State_____
Zip Code_____
Phone Number_____
Signature of Licensed medical doctor, nurse practitioner, physician's assistant, optometrist or ophthalmologist_____
Date

Wyoming Game and Fish Commission, Chapter 35, Section 10. **Making False Statements to Obtain a Permit.** Any person who makes a false statement on an application to obtain a Disabled Hunter Permit or Disabled Hunter Companion Permit or any medical doctor, nurse practitioner, physician assistant, optometrist, or ophthalmologist who makes a false statement on an application in order that a person might fraudulently obtain a Disabled Hunter Permit shall be in violation of this regulation and such violation shall be punishable as provided by Title 23, Wyoming Statutes.

Permits are issued only at Wyoming Game and Fish Department Regional Offices located in JACKSON, PINEDALE, CODY, SHERIDAN, GREEN RIVER, LARAMIE, LANDER, CASPER or the Wyoming Game and Fish Headquarters located in CHEYENNE. Applications can be mailed to: Wyoming Game and Fish Department, License Section, 5400 Bishop Boulevard, Cheyenne, WY 82006-0001.

Revised 10/2015