FISHING LICENSE APPLICATION FOR A PERSON WHO IS HANDICAPPED

(Do not photocopy form)

Attention: False, inaccurate, or misleading information on this application is a criminal offense and violation of Utah Code Title 23 Chapter 19 Section 5

Utah Code Annotated, Section 23-19-36 provides:
A resident who is blind, paraplegic or otherwise permanently disabled so as to be permanently confined to a wheelchair or the use of crutches, or who has lost either or both lower extremities, may receive a free license to fish upon furnishing satisfactory proof of this fact to the Division of Wildlife Resources.

R657-12-2 defines “crutches” means a staff or support designed to fit under or attach to each arm, including a walker, which improve a permanent physical injury or disability.

R657-12-2 defines "Loss of either or both lower extremities" means the permanent loss of use or the physical loss of one or both legs or a part of either or both legs which severely impedes a person's mobility.

Fishing license is issued upon approval of application.

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I HEREBY APPLY FOR A DISABLED FISHING LICENSE IN ACCORDANCE WITH THE ABOVE STIPULATIONS

Customer Identification #_________________________

Name ______________________________ Telephone __________________

Address _____________________________ (City) ____________________ Utah _____________________________ (Zip Code)

Date of Birth __________________________ Gender __________________ Weight __________________ Height ______________

Eye Color ___________________________ Hair Color __________________________

As the person who prepared this application, I declare under the penalty of perjury that to the best of my knowledge the information provided in this application is true and correct, and that the applicant under all prevailing laws and statutes qualifies to apply for and possess this license.

☐ As the applicant I have read and understand the requirements for obtaining this fishing license

Applicant Signature ___________________________ Date ___________________________

If the handicap is not visually apparent, current documentation from a physician must be submitted with this form. Please complete the physician's statement on company letterhead or form, which identifies the physician’s business/affiliation.
PHYSICIAN'S STATEMENT
(Must be completed and signed by physician for physical disabilities other than blindness; or by a physician, ophthalmologist, or optometrist for vision disabilities)

I hereby certify the above named applicant meets the criteria of is blind, paraplegic or otherwise permanently disabled so as to be permanently confined to a wheelchair or the use of crutches, or who has lost either or both lower extremities.

1. The applicant is blind?: □ Yes □ No
   “Blind” means the person has no more than 20/200 visual acuity in the better eye when corrected; or has, in the case of better than 20/200 central vision, a restriction of the field of vision in the better eye which subtends an angle of vision 20 degrees or less.

2. The applicant is paraplegic?: □ Yes □ No

3. The applicant is quadriplegic?: □ Yes □ No

4. The applicant’s physical impairment is Permanent?: □ Yes □ No

5. This physical impairment permanently confines the applicant to the use of crutches, or a wheelchair?: □ Yes □ No
   "Crutches" means a staff or support designed to fit under or attach to each arm, including a walker, which improve a person’s mobility that is otherwise severely restricted by a permanent physical injury or disability.

6. This physical impairment involves the permanent loss of use of at least one of the applicant’s lower extremities?: □ Yes □ No
   "Loss of either or both lower extremities" means the permanent loss of use or the physical loss of one or both legs or a part of either or both legs which severely impedes a person's mobility.

Please explain how the impairment satisfies the state requirement found on this application: (attach additional pages as necessary)
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Dr. Office Use Only:

Physician Signature________________________________________ Date____________________________
Professional Title __________________________________________
Physician Name (print)______________________________________ Telephone Number________________
Affix Office Stamp Here: Address_______________________________
City _______________ State ______ Zip __________

Division Use Only:

Applicant meets the qualifications for this COR □ Y □ N □ Need more information
Region __________ Date:____________ Clerk Initials:____________

NOTES:_____________________________________________________________________________________________
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For more information or additional consideration please contact: Brad Vaske (801) 538-4815
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