



**Applicant Information:**

Customer Identification # \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_

**Requirements:**

1. A person may obtain this Certificate of Registration provided the person requesting the extension: is blind, quadriplegic, upper extremity disabled, 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.
2. "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.
3. Provide the below physician statement confirming the disability (must be signed by a MD or DO)

**As the applicant, I have read and understand the requirements for obtaining this Certificate of Registration**

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician's Statement:**

*(Below must be completed and signed by physician for physical disabilities other than blindness; or by a ophthalmologist or optometrist for vision disabilities.)*

I hereby certify the above named applicant meets the criteria of legally blind, upper extremity disabled, paraplegic, quadriplegic, loss of either or both lower extremities, or otherwise permanently disabled so as to be confined to a wheelchair or the use of crutches.

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 or quadriplegic?: Yes No

3. This physical impairment permanently confines the applicant to the use of crutches or a wheelchair?: Yes No

4. 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.*

5. The applicant is upper extremity disabled? Yes No

*"Upper extremity disabled" means a person who has a permanent physical impairment due to injury or disease, congenital or acquired, which renders the person so severely disabled as to be physically unable to use any legal hunting weapon or fishing device.*

6. The applicant's physical impairment is permanent?: Yes No

**Please explain how the patient's impairment satisfies the state requirements: (attach additional pages if necessary)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Dr. Office Use Only:**

Physician Signature \_\_\_\_\_ Physician Name (print) \_\_\_\_\_  
 Professional Title \_\_\_\_\_ Date \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please reference Rule R657-12 Hunting and Fishing Accommodations for People with Disabilities for any questions and/or concerns:  
<https://wildlife.utah.gov/r657-12-hunting-and-fishing-accommodations-for-people-with-disabilities.html>

For more information or additional consideration please contact:  
**Holly Bosley (801) 538-4815**  
 To submit your application please email, mail, or deliver to a regional office.  
 Email: [hbosley@utah.gov](mailto:hbosley@utah.gov)

Mail to:  
 Attention Licensing  
 1594 West North Temple Suite 2110  
 Salt Lake City, UT 84114

**Attention:** False, Inaccurate, or Misleading Information on this application is a criminal offense and a violation of Utah Code Title 23 Chapter 19 Section 5

DWR USE ONLY		
Approved	Denied	
Need More Information (forward app to SLO)		
Region _____	Date _____	Clerk _____