



WASHINGTON DEPARTMENT OF FISH AND WILDLIFE  
**HUNTER / FISHER DISABILITY STATUS APPLICATION**  
 Mail to: WDFW, Licensing Division, 600 Capitol Way N, Olympia, WA 98501-1091  
 Fax to: (360) 902-2466

Please Print Clearly										<b>APPLICANT INFORMATION REQUIRED</b>									
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		SSN									
WILD ID				EMAIL				PHONE											

Please select one or both of the following applications :  Fishing  Hunting

**Physician:** please *check and sign* one or more following boxes to describe above applicant.

\_\_\_\_\_  
 Physician Signature  **Permanent non-operable physical disability:** Upper Extremity Impairment

\_\_\_\_\_  
 Physician Signature  **Permanent non-operable physical disability:** Lower Extremity Impairment

A person who has a permanent disability and is not ambulatory over natural terrain without a lower extremity prosthesis or must permanently use a medically prescribed assistive device for mobility, including, but not limited to, a wheelchair, crutch, cane, brace, walker, or oxygen bottle; or A person who has a permanent disability and is physically incapable of holding and safely operating a firearm or other legal hunting/fishing device; or This definition includes, but is not limited to, persons with a permanent upper or lower extremity impairment who have lost the use of one or both upper or lower extremities, or who have a diagnosed permanent disease or disorder which substantially impairs or severely interferes with mobility or the use of one or both upper or lower extremities for holding and safely operating a firearm or other legal device. Remember, physical conditions relating completely to the comfort level of the applicant are not acceptable criteria for the issuance of disability status.

\_\_\_\_\_  
 Physician Signature  **Permanent non-operable physical disability:** Blind / Visually Impaired

Central visual acuity does not exceed 20/200 in the better eye with corrective lenses, or the widest diameter of the visual field is not greater than 20 degrees.

\_\_\_\_\_  
 Physician Signature  **Permanent Developmental disability:** Mental / Physical Impairment

A cognitive intellectual disability such as: cerebral palsy, down syndrome, epilepsy, autism, or another neurological condition of an individual found by the secretary to be closely related to an intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities, which **originates before the individual attains age eighteen**, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual. RCW 71A.10.020(4). **NOT included:** PTSD, Bi-polar, ADD, ADHD, Anxiety, Parkinson's, Multiple Sclerosis.

**I am a licensed physician for the above named person, and by my signature do certify under penalty of perjury of the law, the above applicant has a permanent disability as I have indicated.**

**X** \_\_\_\_\_  
 Licensed Physician's Signature      ARNP or PA Signatures not accepted      Date

Physician's Name \_\_\_\_\_ Title \_\_\_\_\_  
 (Please print clearly)

Address \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number: (      ) \_\_\_\_\_ Medical License Number: \_\_\_\_\_  
*Mandatory*

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

**WDFW USE ONLY**

Approved By:

Date:



# WASHINGTON DEPARTMENT OF FISH AND WILDLIFE HUNTER / FISHER REDUCED FEES APPLICATION

Mail to: WDFW, Licensing Division, 600 Capitol Way N, Olympia, WA 98501-1091

Fax to: (360) 902-2466

## 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		SSN			
WILD ID				EMAIL				PHONE					

### COMPLETE FOR REDUCED FEE HUNTING AND/OR FISHING LICENSES

Both selections are automatic for this application :  Fishing  Hunting

*This is for reduced fees only. This does not provide access to assistance cards, programs or facilities. You must fill out the hunter/fisher disability application to receive Disability Status.*

**Resident Veterans:** with at least 30% service connected disability as verified by VA letter (RCW 77.32.480)

**Resident Veterans 65 years of age or older:** with a service connected disability as verified by VA letter (RCW 77.32.480)  
*Veterans must include with this application a copy of their VA letter showing name and rating clearly.*

**Resident who permanently use a wheelchair:** as certified by the physician's signature below (RCW 77.32.480)

**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 (RCW 77.32.480)

**Resident with a Developmental Disability:** as determined by DSHS Authority or Physician's certification below (RCW 71A.10.020)  
*The cognitive intellectual developmental disability such as cerebral palsy, must have originated before the individual attained age eighteen NOT included: PTSD, Bi-polar, ADD, ADHD, Anxiety, Depression, Parkinson's, Multiple Sclerosis.*

Only licensed physician's may certify a disability on this application. ARNP or PA's not accepted.

*I am a licensed physician for the above named person, and by my signature do certify under penalty of perjury of the law, the above applicant has a permanent disability as I have indicated.*

X \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name \_\_\_\_\_ Title \_\_\_\_\_  
*(Please print clearly)*

Address \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ Medical License Number: \_\_\_\_\_  
*Mandatory*

*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 \_\_\_\_\_

WDFW USE ONLY	
Approved By:	Date: