



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 to take wildlife from a vehicle who is paraplegic or 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. Certificate of Registration holder must be accompanied by and hunt with a person who is physically capable of assisting the holder in recovering wildlife.
3. Only the person with the Certificate of Registration in possession allowing them to hunt from a vehicle may discharge a firearm or bow from, within, or upon any motorized terrestrial vehicle.
4. Provide the below physician statement confirming the disability (must be signed by a licensed MD, DO, or PA).

[] 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 a licensed MD, DO, or PA)

I hereby certify the above named applicant meets the criteria of legally blind, upper extremity disabled, paraplegic, quadriplegic, losing 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 paraplegic?: Yes [] No []
2. This physical impairment permanently confines the applicant to the use of crutches or a wheelchair?: Yes [] No []
3. 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.
4. 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 a DWR office.

To submit your application please email, mail, or deliver to a regional office.
Email: dwrlicensesale@utah.gov
Phone: (801) 538- 4815 OR
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 _____