



# APPLICATION FOR SPECIAL PERMIT FOR DISABLED HUNTER

State Form 10691 (R11 / 1-24)

INDIANA DEPT. OF NATURAL RESOURCES

Attn: Licensing  
Division of Fish and Wildlife  
402 W. Washington St., Rm W273  
Indianapolis, IN 46204-2781  
Telephone: (317) 232-4102  
Fax: (317) 232-8150  
wildlifepermits@dnr.in.gov  
www.wildlife.in.gov

### INSTRUCTIONS:

1. Please type or print information **legibly**.
2. Provide all information requested or your application will be returned without processing.
3. **The signature from a licensed physician or nurse practitioner must be included on page 3 of the application.**
4. Mail, fax, or email completed application to address shown in upper right corner.

## APPLICANT INFORMATION

Name of Applicant ( <i>first, middle, last</i> )	Date of Birth ( <i>month, day, year</i> )	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address ( <i>number and street</i> )	Height	Weight	Eye Color
City, State, and ZIP Code	Telephone Number (    )		
County	Email		

## APPLICANT'S DESCRIPTION OF DISABILITY AND REQUEST

Briefly describe your disability:

1) What type of equipment do you use?  Firearm  Muzzleloader  Bow and arrow  Crossbow

2) Do you need a vehicle to (*check all that apply*):  Gain access  Carry your game  Hunt from  
If yes, what type of vehicle?  Truck  ATV  Other

3) Do you hunt on public (*state or federal*) property?  Yes  No

Under the penalty of perjury (IC 35-44-2-1), I affirm that the information supplied by me is true and correct.

Signature of applicant

Date (*month, day, year*)

**Note to Applicant:** The information on the following pages must be completed and signed by a **licensed physician or nurse practitioner**. The information is required only once if the disability, as described, is of a permanent nature. A new application is required if the applicant's status changes (*for example, stationary vehicle use becomes necessary for an applicant whose previous health condition(s) did not require that option when prior application was made*).

**Pages 2 and 3 are to be completed by a licensed physician or nurse practitioner.**

## FOR OFFICE USE ONLY

Application Approved  Application Disapproved  P  T  SV  VA

Signature of Fish and Wildlife Staff

Date (*month, day, year*)

**TO BE COMPLETED BY LICENSED PHYSICIAN OR NURSE PRACTITIONER**

Name of Physician	Telephone Number (    )
Name of Clinic or Hospital	
Address (number and street)	
City, State, and ZIP code	
This is to certify that _____ has been in my care since _____ for the medical conditions described below. (date)	

**Physician or Nurse: Please complete all applicable sections below.**

NOTE TO PHYSICIAN OR NURSE: The Indiana Department of Natural Resources may issue a special permit for the taking of wildlife by an individual who has a disability of such a nature that it is difficult or impossible for the hunter to be in a position to take wildlife unless given special consideration. For the purpose of special disability hunting permits, a person is disabled if he/she has a physical impairment due to injury or disease, congenital or acquired. Generally, permits are issued to hunt from a vehicle for persons who cannot walk or have great difficulty in walking.

**REQUIRED: What is the cause of the disability?** Please provide the name of the specific disease or injury.

**REQUIRED: Are the conditions permanent or temporary?**     Permanent     Temporary     Unknown

If the conditions are temporary, please indicate an estimated timeframe for the patient's recovery.

**Is an assistive device needed to help the applicant walk (check all that apply)?**     Cane     Wheelchair     Other  
If yes:     Part-time     Full-time

**PLEASE FILL OUT THE FOLLOWING APPLICABLE SECTIONS.**

**A. Cardiovascular Conditions**

Describe walking limitations without pain or shortness of breath, including estimated distance on flat or rough terrain.

Describe upper body movement limitations without pain.

If known, what is the American Heart Association's Heart Disease classification? (check one)     1     2     3     4     5

If applicable, when was the applicant's surgery? (month, day, year)

Are there any unusual circumstances causing pain? (Please explain)

**B. Pulmonary Conditions** (continued on page 3)

Provide specific details of limitations of activity, especially walking without shortness of breath, such as distance on flat or rough terrain.

Describe any upper body limitations of activity or strength related to pulmonary conditions.

What restrictions does the applicant have performing normal daily activities?

**C. Neurological conditions**

Describe walking limitations (*especially in terms of terrain and/or distance*).

Describe any upper body limitations of activity or strength related to neurological conditions.

**D. Arthritic Conditions**

What type of arthritis?	What joints are affected?
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If lower body is affected, how well can the applicant walk (*especially in terms of terrain and distance*)?

**E. Amputations/Orthopedic Conditions**

Amputation: Indicate the nature and extent of the amputation(s) and prosthetic devices, if any, the applicant uses.

Orthopedic conditions: Describe any walking limitations (*especially in terms of terrain and distance*).

**F. Other**

If the extent of applicant's physical limitations (*upper body strength/movement, walking*) cannot be described above, please explain here, provide an attachment, or provide a medical justification for applicant's requested method of hunting.

*Under the penalty of perjury (IC 35-44-2-1), I affirm that the information supplied by me is true and correct to the best of my knowledge.*

Signature of Licensed Physician or Nurse Practitioner	Date ( <i>month, day, year</i> )
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License Number