



APPLICATION FOR SPECIAL PERMIT FOR DISABLED HUNTER

State Form 10691 (R10 / 3-12)

DEPARTMENT OF NATURAL RESOURCES
DIVISION OF FISH AND WILDLIFE
Attn: Permit Coordinator
402 W. Washington St., Rm. W273
Indianapolis, IN 46204-2781
Telephone: (317) 232-4102

INSTRUCTIONS:

1. Please type or print information **legibly**.
2. Provide all information requested or your application will be returned without processing.
3. **A Statement of Disability with original signature from a licensed physician must be included on each application.**
4. Mail 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
City, State, and ZIP Code	Eye Color	Hair Color
County	Telephone Number ()	

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
If yes, do you hunt on the Hoosier National Forest? 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 (<i>month, day, year</i>)
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Note to Applicant: The Physician's Statement of Disability on the following pages must be completed and signed by a **licensed physician**. The Physician's Statement of Disability is required only once if the disability, as described, is of a permanent nature. A new application and Physician's Statement of Disability are 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*).

(Physician's Statement of Disability Continued on Next Page)

FOR OFFICE USE ONLY	
<input type="checkbox"/> Application Approved <input type="checkbox"/> Application Disapproved	<input type="checkbox"/> P <input type="checkbox"/> T <input type="checkbox"/> SV <input type="checkbox"/> VA <input type="checkbox"/> DL
Signature of Fish and Wildlife Staff Specialist	Date (<i>month, day, year</i>)

TO BE COMPLETED BY LICENSED PHYSICIAN

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

Physician: Please complete all applicable sections below.

NOTE TO PHYSICIAN: 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 him/her 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.

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

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

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.

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.

D. Arthritic Conditions

What type of arthritis?

What joints are affected?

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.

This form will be returned to the applicant if all applicable sections are not fully completed, or if a copy/fax of this form is received in place of the original.

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

Signature of Licensed Physician

Date (*month, day, year*)

License Number