DISABLED CROSSBOW PERMIT APPLICATION

FLORIDA FISH AND WILDLIFE CONSERVATION COMMISSION
2590 EXECUTIVE CENTER CIRCLE, SUITE 200, TALLAHASSEE, FL 32301

(Applicant Name) ______________________ (Social Security Number) ______________________ (Date of Birth) Mo. ____ Day ____ Yr ______

(Mailing Address) ______________________ (City) ______________ (State) ______ (Zip) ______

Sex_____ Race_____ Height _____FT_____IN Weight ________lbs. Eye Color ______________ Hair Color ________________

Telephone 8-5 (___) ____________ Telephone Mobile or Evening (___) ____________

☐ **New Applicant**

☐ **Replacement**

☐ **Renewal**

I do hereby ***attest*** and ***affirm*** that the information provided is true and correct.

______________________________ Applicant's Signature ____________ Date

The Florida Fish and Wildlife Conservation Commission (FWC) collects social security number (SSN) for the issuance of recreational and professional fishing or hunting licenses or permits to an individual in accordance with s. 372.561 F.S. and 42 USC 666 for the purposes of administration of the Title IV-D program for child support enforcement, use by the commission, and as otherwise provided by law.

PHYSICIAN'S STATEMENT OF DISABILITY

This is to certify that ____________________ ___________ is, in my professional opinion, **permanently** incapable of drawing any type of bow with a minimum draw weight of **40 lbs**. This is a result of the following:

☐ Missing right hand or arm ☐ Missing left hand or arm

☐ Is at least 80% **permanently** disabled in right hand or arm (as determined using standards outlined in the Guide to Evaluation of Permanent Impairment Rating as published by the AMA)

☐ Is at least 80% **permanently** disabled in left hand or arm (as determined using standards outlined in the Guide to Evaluation of Permanent Impairment Rating as published by the AMA)

☐ Is **permanently** unable to ambulate without the aid of crutches, wheelchair, two leg braces or two leg prostheses.

☐ Other - Please explain the **permanent disability** that renders this patient incapable of drawing any type of bow with a minimum draw weight of **40 lbs**. ____

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______________________________ Print Physician's Name ______________________ Physician's License Number (Must begin with ME, RS, LL, OS or CH)

____
Mailing Address City State Zip

__(_____)______________________ Physician's Telephone Number _(______)____________________ Physician's Fax Number

I certify that the above-mentioned patient is **permanently incapable of pulling a bow with a draw weight of 40 lbs**.

______________________________ Physician's Signature ____________ Date

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Any person who knowingly makes a false or misleading statement in an application or certification under Section 320.0848, F.S., commits a misdemeanor of the second degree, punishable as provided in Section 775.082 or 775.083 F.S.