Oregon Department of Fish Wildlife
Disabled Clam Harvester Permit
Application

Please Print

Full Name: ___________________________________________________
Address: _____________________________________________________
City, State and Zip: ___________________________________________
Date of Birth: _______________________________________________
Phone: _____________________________________________________

Under the authority of OARs 635-011-0100 and 635-039-0090, certain individuals with disabilities that prevent them from harvesting clams for recreational purposes are allowed to have an assistant harvest clams for them.

1. A person may assist a disabled clam harvester, provided:
   
a) The disabled clam harvester has one of the following: a valid Disabled Clam Harvester Permit, an Oregon Disabilities Hunting and Fishing Permit, a Disabled Veterans Angling License, a Wheelchair Angling License, or a Blind Angler License in possession on the clam bed;
b) The person assisting the permit holder of one of the permits or licenses listed in 1a (above) has a copy of the permit or license in possession on the clam beds;
c) Both the assistant and Disabled Clam Harvester Permit holder have their own containers for clams;
d) Both the assistant and Disabled Clam Harvester Permit holder have current Recreational Shellfish Licenses; and
e) The Disabled Clam Harvester Permit holder is within 100 feet of the assistant while the assistant is harvesting.

Persons wishing to apply for a Disabled Clam Harvester Permit must have a licensed physician thoroughly answer all questions pertaining to the disability. Physicians must completely fill out the section in the application detailing how the applicant meets the criteria. Physicians who are authorized to certify a harvester’s disability are: Doctors of Medicine, Osteopaths, Podiatrists, Chiropractors, Naturopaths and Nurse Practitioners.

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

If you wish to apply for a Disabled Clam Harvester Permit, please make sure you and your physician completely fill out this application and mail it to:

ODFW
Disabled Clam Harvester Permit
2001 Marine Drive, Rm. 120
Astoria, OR 97103 Phone: 503-325-2462

PLEASE ALLOW UP TO 10 BUSINESS DAYS FOR YOUR PERMIT TO BE PROCESSED
TO BE COMPLETED BY A LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER

Incomplete applications will not be accepted. All qualifying sections that meet the applicant’s disability must be filled out completely. Please read carefully.

1. Applicant has severely limited mobility because of paralysis or the loss of use of some or all of the person’s legs or arms that prevents them from harvesting clams.

In accordance with Oregon Department of Fish and Wildlife regulations, does the applicant’s disability meet the definition above?

   YES: ________PHYSICIAN’S INITIALS

   NO: ________PHYSICIAN’S INITIALS

If answered “YES”, please indicate the duration of the condition;

   PERMANENT: __________

   TEMPORARY: __________ DATE ENDING: ______________

In LAYMEN’s TERMS, please describe the nature of the condition as it impacts the applicant’s ability to participate in clam harvesting. It is important to note how the impairment would appear to a law enforcement officer. (Please print)

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2. Applicant is affected by loss of vision or substantial loss of visual acuity or visual field beyond correction.

In accordance with Oregon Department of Fish and Wildlife regulations, does the applicant’s disability meet the definition above?

YES: ________PHYSICIAN’S INITIALS

NO: ________PHYSICIAN’S INITIALS

If answered “YES”, please indicate the duration of the condition;

PERMANENT: ________

TEMPORARY: ________ DATE ENDING: ____________

In LAYMEN’s TERMS, please describe the nature of the condition as it impacts the applicant’s ability to participate in clam harvesting. It is important to note how the impairment would appear to a law enforcement officer. (Please print)

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3. Applicant has any other disability that prevents them from walking without the use of an assistive device, or that causes the person to be unable to walk more than 200 feet, including but not limited to: Chronic heart condition, emphysema, arthritis, rheumatism, ulcerative colitis or related chronic bowel disorder.

In accordance with Oregon Department of Fish and Wildlife regulations, does the applicant’s disability meet the definition above?

YES: _______ PHYSICIAN’S INITIALS

NO: _______ PHYSICIAN’S INITIALS

If answered “YES”, please indicate the duration of the condition;

PERMANENT: ________

TEMPORARY: ___________ DATE ENDING: ______________

In LAYMEN’s TERMS, please describe the nature of the condition as it impacts the applicant’s ability to participate in clam harvesting. It is important to note how the impairment would appear to a law enforcement officer. (Please print)

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I hereby swear, under penalty of perjury that I, the undersigned, am a Licensed Physician or Certified Nurse Practitioner for the above named applicant, and do hereby certify the applicant to be disabled as defined by the above conditions:

Licensed Physician Name (please print):__________________________________________

Physician’s License Number: ______________________________

Signature of Licensed Physician: _______________________________________________

Date: __________________________

Address: _________________________________________________________________

City: ______________________________

State: _____________________________

Zip Code: __________________________

Phone Number: ____________________ FAX: ___________________________

I hereby swear, under penalty of perjury, that I am disabled as described above.

Applicants Name (please print): _______________________________________________

SIGNATURE of Applicant: _____________________________________________________

Date: ___________________________