ODFW Use only
Received date:_____

Issued date:_____

Draw Lock Device Permit Application

Mail Applications to:
Attn: Wildlife Permits
ODFW Headquarters Office
4034 Fairview Industrial Dr SE
Salem, OR 97302

Questions? Please Contact:
Wildlife Permits Information
(503) 947-6315
Wildlife.Permits@odfw.oregon.gov

Thank you for your interest in this program.

TO BE COMPLETED BY ALL APPLICANTS:
NOTE: INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED!

RENEWAL: ☐

FIRST TIME APPLICANT: ☐

Hunter/Angler Id Number: _____ Hunting Season Year: _____

Name of Applicant: _____
Last First Middle Initial

Date of Birth: _____ Gender: Male ☐ Weight: _____ Height: _____
mm/dd/yyyy Female ☐

Mailing Address: _____

City:_____State:_____Zip Code: _____

Phone Number: (_____)_____- _____ E-mail:_____
Area

Applicant has a physical impairment that prevents the person from holding or shooting a bow;

In accordance with the Oregon Dept. of Fish & Wildlife regulations, does the applicant's disability meet the definition above?

YES: _____PHYSICIAN'S **INITIALS** REQUIRED

NO: _____PHYSICIAN'S **INITIALS**

In "LAYMAN'S TERMS", PLEASE DESCRIBE THE NATURE/DIAGNOSIS OF THE PHYSICAL IMPAIRMENT AS IT IMPACTS THE APPLICANT'S ability to participate in big game hunting **and** particularly **how the impairment would appear to a law enforcement officer.**
(Please be specific and use additional sheets if needed)

_____

_____

_____

_____

The applicant's impairment prevents them from drawing/holding a bow:

Yes: ____ No: ____

The applicant's impairment can be characterized as:

Permanent: ____ Temporary (may regain function): ____

TO BE COMPLETED BY LICENSED PHYSICIAN, LICENSE PHYSICIAN ASSISTANT, OR CERTIFIED NURSE PRACTITIONER:

All fields are required.

I hereby swear, under penalty of perjury that I, the undersigned, am a licensed physician, licensed physician assistant, or certified nurse practitioner for the above named applicant, and do hereby certify the applicant to be disabled as defined by (ORS 496.018):

(1) Written certification from a licensed physician, licensed physician assistant or certified nurse practitioner which states that the applicant:

a) Is permanently unable to walk without the use of, or assistance from, a brace, cane, crutch, prosthetic device, wheelchair, scooter or walker fulltime. Note: A brace is defined as an orthosis that is prescribed by a physician and fabricated by an orthotist certified by the American Board for Certification in Orthotics and Prosthetics, Inc; OR

b) Is restricted by lung disease to the extent that the person's forced expiratory volume for one second, when measured by a spirometer, is less than 35 percent predicted, or arterial oxygen tension is less than 55 mm/Hg on room air at rest; OR

c) Has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV, according to standards established by the American Heart Association; OR

d) **Has a physical impairment that prevents the person from holding or shooting a** firearm or **bow**, or from holding a fishing rod in hand; OR

e) Has central visual acuity that permanently does not exceed 20/200 in the better eye with corrective lenses, or the widest diameter of the applicant's visual field is no greater than 20 degrees;

Medical Practitioner's License Number: _____

Medical Practitioner's Name (please print)**:** _____

Signature of Medical Practitioner: _____

Date: _____

Street Address or Box Number: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: (_____**)**_____**-**_____

TO BE COMPLETED BY APPLICANT:

**All fields are required.

I hereby swear, under penalty of perjury, that I am disabled as described in ORS 496.018.

ORS 496.018

(1) Written certification from a licensed physician, licensed physician assistant or certified nurse practitioner which states that the applicant:

a) Is permanently unable to walk without the use of, or assistance from, a brace, cane, crutch, prosthetic device, wheelchair, scooter or walker fulltime. Note: A brace is defined as an orthosis that is prescribed by a physician and fabricated by an orthotist certified by the American Board for Certification in Orthotics and Prosthetics, Inc; OR

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d) **Has a physical impairment that prevents the person from holding or shooting a** firearm or **bow**, or from holding a fishing rod in hand; OR

e) Has central visual acuity that permanently does not exceed 20/200 in the better eye with corrective lenses, or the widest diameter of the applicant's visual field is no greater than 20 degrees.

Additionally, I hereby swear, under penalty of perjury, that all the information in this application is true and accurate and has been completed by a licensed physician, license physician assistant or certified nurse practitioner.

Applicant Name (please print):_____

SIGNATURE of Applicant: _____

Date: _____