

Permit # _____
Issue date: _____

**PHYSICALLY CHALLENGED HUNTER'S PERMIT APPLICATION**

Name \_\_\_\_\_  
Last First Middle Jr. or Sr.

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ LA Drivers License # \_\_\_\_\_

Date \_\_\_\_\_ Hunter Education Certification # \_\_\_\_\_  
(Required if you were born on or after September 1, 1969)

**Type of permit you are applying for (please circle choice):**

Class I: Wheelchair Bound      Class II: Mobility Impaired      Class III: Amputee (upper extremity)

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***This section must be completed by a Louisiana Licensed Medical Doctor***

In an effort to insure that all permittees meet the requirements of the law, please review this information and answer the following questions.

Permanent Disability \_\_\_\_\_      Temporary Disability \_\_\_\_\_  
(To qualify the disability must be for at least one year)

Describe the specific nature of the disability and the reason this applicant qualifies for the requested permit.

\_\_\_\_\_

\_\_\_\_\_

I hereby affirm that I am a medical doctor licensed to practice medicine in the state of Louisiana and further state that the patient listed above meets the criteria as described in the guidelines for the Physically Challenged Hunter Program and should be issued the appropriate permit.

Physician's Name (Printed) \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Approved: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of licensed Physician)

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**OFFICE USE ONLY**

Enforcement Captain: \_\_\_\_\_ Date \_\_\_\_\_

Division Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

**Return the original signed and completed application by mail to:**

**LDWF - Region 7 (DHP)**      225 765 2360 (Phone)  
**P O Box 98000**      225 763 5447 (Fax)  
**Baton Rouge, LA 70898**