RESIDENTS WITH TOTAL DISABILITY

Application For

REDUCED FEE HUNTING & FISHING LICENSE

Eligibility: The applicant must be a **resident** of South Dakota who is:

- a paraplegic or is physically unable to walk;
- or has a visual acuity of 20/200 or less in the better eye with correcting lenses or has a limited field of vision such that the widest diameter subtends an angular distance of no greater than 20 degrees;
- or is developmentally disabled.

Submission: Application papers, along with the $10.00 fee, must be submitted to:

Game, Fish and Parks
Disability License
20641 SD Hwy 1806
Ft. Pierre, SD 57532

Upon completion of this form and with the attached proof of eligibility, South Dakota residents will receive a $10 reduced fee license valid for four years. For those who are physically unable to walk or legally blind, this license will be valid for small game hunting and fishing.

For those who are developmentally disabled, this license will be valid for fishing only.

(This section to be completed by applicant or applicant's legal guardian)

Please Print:

1. Name: _____
   Last First Middle Initial
2. Address: _____
   Street, Box Number, Rural Route City State (Zip +4)
3. Social Security Number (last four only) _____ Phone Number: (_____) _____ - _____
4. Height: Feet: ____ Inches: _____ Weight: _____ Date of Birth (MDY): _____ / _____ / _____
5. Are your hunting/fishing privileges under revocation or suspension in any state or country?

   YES ☐ NO ☐ (Check one) If yes, you are not eligible.

6. I hereby certify under penalty of law that I meet the hunting/fishing residency requirements and all information herein is true and correct. I affirm that I am eligible for the license in which I am applying. I affirm that my hunting privileges and my fishing privileges are not in any way currently revoked or suspended in any state or country. I understand that if my hunting, or fishing privileges are revoked or suspended in any state or country I am not eligible for that privilege in this state, and I understand that any misrepresentations of fact or identity may result in criminal prosecution and loss of privileges. I also agree to authorize my physician(s) and medical staff to share any of my applicable medical history with Game, Fish and Parks staff to verify that I qualify for this reduced fee license.

_____ ____ / ____ / _____
Applicant or Applicant's Guardian Signature Date

This section to be completed by a licensed medical professional listed below

Certification by currently licensed medical, osteopathic or chiropractic doctor for those who are physically unable to walk; optometrist or ophthalmologist for those who are legally blind; medical doctor or letter from the Department of Social Services for those with developmental disabilities. If you are sending a letter from the Department of Social Services verifying a developmental disability with your application, you do not need this section filled out.

Physician's Statement: Under penalty of perjury, I hereby certify that the above named applicant has (please check all that apply):

☐ paralysis of the lower half of the body including both legs.

☐ a total absence of voluntary muscle control that allows the applicant to walk.

☐ a visual acuity of 20/200 or less in the better eye with corrective lenses or has a limited field of vision such that the widest diameter subtends an angular distance of no greater than 20 degrees.

☐ a severe chronic developmental disability that meets **all** of the following requirements:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. **Is manifested before the person attains age twenty-two;**
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
5. Reflects the person's need for an array of generic services, met through a system of individualized planning and supports over an extended time, including those of a life-long duration.

SIGNATURE _____ (PRINT) _____
(Currently licensed medical, osteopathic or chiropractic doctor; or optometrist or ophthalmologist)

_____
Address City State Zip

(_____) _____ - _____ ____ / ____ / ____
Area code and Phone Number Date

For Office Use Only: **Card number:** _____ **Date Issued:** ____ **/** ____ **/** _____