APPLICATION FOR EXCEPTION TO POLICY
ATV/ORV USE WHILE HUNTING
DUE TO DISABILITY

DIRECTORATE OF PUBLIC WORKS
NATURAL RESOURCES MANAGEMENT BRANCH
ATTN: Hunting ETP
10208 First Division Road, Bldg. 5889
Fort Benning, GA 31905
(520) 674-0594

Instructions:

- Please type or print information legibly.
- Provide all information requested, or your application will be returned without processing.

Applicant Information

Full Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Email: _____

Qualification Criteria

Please select one of the following options. If you select option B, you must have the 'To be Completed by Medical Provider' section filled out by a licensed medical provider.

A. ☐ I meet one of the following criteria (Medical Provider's signature not required). Please check the appropriate box and provide documentation. NOTE: *If approved, the permittee must supply the supporting document(s), provided with the application and referenced in the applicant's Exception to Policy (ETP), for the document to be valid. Failure to comply will result in revocation of ATV/ORV ETP.*

☐ Receiving Social Security disability benefits
☐ 100% disability rating, or permanently and totally disabled, as determined by VA
☐ Disability retirement from the Railroad Retirement Board
☐ Total and permanent disability as determined by Medicare or Medicaid

Applicant Signature: _____ Date: _____

B. ☐ I am submitting a Medical Provider Certification of Disability (MD/DO, PA, NP).
To be Completed by Medical Provider (MD/DO, PA, NP):

Name of Provider: _____

Name of Clinic or Hospital: _____

Address: _____

City, State, and ZIP code: _____

Phone: _____ Email: _____

Please check all that apply for the individual:

☐ Cannot walk at all

☐ Cannot walk without crutches, walker, prosthesis, or other physical assistance

☐ Cannot ambulate greater than 50 yards without rest due to difficulty breathing, heart problems, pain, or other medical impairment

☐ Cannot lift or drag 50 pounds for 50 yards without assistance

☐ Has lost a limb or vital organ

☐ Cannot hunt alone due to visual or mental impairment

Are the conditions permanent or temporary?

☐ Permanent ☐ Temporary*

*If the conditions are temporary, please indicate an estimated timeframe for the patient's recovery:

_____

_____

Medical Provider's Signature: _____

Date: _____ State & License Number: _____

For Official Use Only

Application Status: ☐ Approved ☐ Denied

Reviewed By: _____ Date: _____

Notes: _____

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