MI Form  Mobility Impaired Certification Application

Provisions and Procedures For Certification
The New Mexico Department of Game and Fish, in accordance with Title 19 NMAC, may provide mobility impaired hunting opportunities for pronghorn, deer, elk and oryx to disabled individuals who are certified as meeting at least one of the following criteria: permanent restriction to a wheelchair, a walker, two crutches, severe permanent restriction of movement in both arms, or a combination of permanent disabilities which cause comparable substantial functional limitations.

Applicants first must register for a Customer Identification Number (CIN) at www.wildlife.state.nm.us. Please send this completed application to NMDG&F, Licensing Section, P.O. Box 25112, Santa Fe, NM, 87504-5112.

The Mobility Impaired Certification expires after 48 months (4 Years) and MUST be renewed.

Part 1  Applicant’s Information

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<th>Last Name</th>
<th>First Name</th>
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Address

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<th>Zip Code</th>
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Daytime Phone

Home Phone

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<tr>
<th>Last Four Digits of SSN</th>
<th>Customer Identification Number or Birth Date (MM/DD/YYYY)</th>
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M □ F □ Height _________ Weight ___________ Eye Color _______ Hair Color _______

I attest that the above information is true and correct and that I have a qualifying permanent impairment and I am eligible for a Mobility Impaired Certification.

Signature ________________________ Date ____________

Part 2  Physician’s Statement

I certify that __________________________ has the following permanent mobility restriction(s) as described below. Please check one or more.

1. __ Permanently restricted to the use of _____ wheelchair _____ walker _____ or two crutches
2. __ Severe permanent restriction of movement of both arms
3. __ Combination of permanent disabilities which cause comparable substantial functional limitation. Please describe:

________________________________________________________________________
________________________________________________________________________

Signature of Certifying Physician ___________________________ Date ____________

Printed Name of Certifying Physician __________________________

Medical License, Permit or Board Certification Number ___________ State ________

Address __________________________________________ Phone Number ________

For Department Use Only

6/27/11