# New Mexico Department of Game and Fish

*Conserving New Mexico's Wildlife for Future Generations*

# MI Form: Mobility Impaired Certification Application

**Provisions and Procedures for Certification:**

The New Mexico Department of Game and Fish (NMDGF), 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: 1) permanent restriction to a wheelchair, walker or crutches; or 2) one or more permanent conditions or disabilities which substantially limit the individual's ability to walk. Mobility Impaired Certification expires 48 months (4 Years) from date of processing, and MUST be renewed. Applicants first must register for a Customer Identification Number (CIN) at www.wildlife.state.nm.us. Please e-mail this completed application to: specialhunts@state.nm.us; fax to: 505-476-8180; or mail to NMDGF, Licensing Section, P.O. Box 25112, Santa Fe, NM, 87504-5112. For assistance, telephone:1-888-248-6866.

**NMDGF Use Only**

**Part 1:** APPLICANT INFORMATION

Last Name ____ First Name ____ M.I. ____

Address ____

City ____ State ____ ZIP ____ – ____

Daytime Telephone with area code ( ) ____ – ____ Home Telephone with area code ( ) ____ – ____

Last 4 digits of SSN ____ Customer Identification Number or Birth Date (MM/DD/YYYY) ____ – ____

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(s) and am eligible for Mobility Impaired Certification.

Signature: ______________________ Date: ______________

**Part 2:** PHYSICIAN STATEMENT

I certify that the applicant 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 crutches
- ☐ 2. One or more permanent conditions or disabilities which substantially limit the individual's ability to walk.

Please describe disabilities for each case: ______________________

______________________

Signature: ______________________ Date: ______________
Certifying Physician

Printed Name of Certifying Pysician - First ____ Last ____ M.I. ____

Address ____

City ____ State ____ ZIP ____ Office Telephone with area code ( ) ____ – ____

Medical License, Permit or Board Certification Number ______________ State Issued ______________