



VISUAL DISABILITY PERMIT APPLICATION FORM



Before completing this application please read the Nevada Administrative Code 503.146 printed below.

Please complete and sign and return this application to, Nevada Department of Wildlife, License Office-Special License and Permits, 6980 Sierra Center Parkway, Ste-120, Reno, NV 89511. Expect up to 10 days for processing.

A licensed physician, ophthalmologist's or optometrist's certification of eligibility for the permit and signature on this form is required (next page).

Applicant and physician are both certifying that the following information is truthful, and understand that any person who makes any false statement or furnishes false information to obtain this permit is guilty of a misdemeanor, per NRS 502.060 and NRS 630.3062. Should applicant be granted a visual disability scope permit, he or she must carry it on their person along with a valid license while hunting in the field.

THIS SECTION TO BE COMPLETED BY APPLICANT

Please type or print clearly. An incomplete application will be returned with no action taken.

SOCIAL SECURITY NO/SPORTSMAN ID:		DATE OF BIRTH:			
NAME:		(FIRST)		(INITIAL)	
(LAST)					
MAILING ADDRESS:					
CITY:		STATE:		ZIP CODE:	
PHYSICAL ADDRESS:					
CITY:		STATE:		ZIP CODE:	
GENDER:	HEIGHT:	WEIGHT:	HAIR COLOR:	EYE COLOR:	TELEPHONE:
DRIVER'S LICENSE NO.:			STATE:		
SIGNATURE: I the signatory holder in signing this application, hereby state that I am entitled to this license under the laws of the State of Nevada and that no false statement has been made by me to obtain this license.					

Chapter 503 of NAC is hereby amended by adding thereto a new section to read as follows:

1. The Department may issue a scope permit to a person with a visual disability. The scope permit authorizes a person with a visual disability to hunt, during a type of hunt that is restricted to muzzle-loading firearms, or bow using a 1x magnification rifle scope that is mounted on a muzzle-loading rifle or bow. A person using such a permit shall present the permit upon the request of a law enforcement officer.
2. An application for a scope permit must:
 - (a) Be submitted to the Department on a form provided by the Department;
 - (b) Include a certificate issued by a licensed physician certifying that the applicant has a visual disability; and
 - (c) Include any other information required by the Department to issue the permit.
3. A scope permit issued pursuant to this section is valid for 1 year after the date it is issued.
4. As used in this section, "visual disability" means a visual impairment which substantially limits a major life activity and is not correctable by glasses or contact lenses.

(See next page for physician's certification)

THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN, OPHTHALMOLOGIST OR OPTOMETRIST

Please type or print clearly. An incomplete application will be returned with no action taken.

The named applicant is applying for a special permit to use a 1X magnification scope with a muzzleloader or bow during a muzzleloader or bow-only hunt. The applicant, pursuant to NAC 503.146 must have a visual disability which substantially limits a major life activity and is not correctable by glasses or contact lenses.

Please describe the visual disability: _____

Does this visual disability limit a major life activity? [] Yes [] No.

If yes, please describe how? _____

Is this visual disability correctable by glasses or contact lenses? [] Yes [] No

PHYSICIAN'S FULL NAME **TITLE**

MAILING ADDRESS: (NUMBER)

ADDRESS CONTINUED (CITY, STATE, ZIP CODE)

PHYSICIANS LICENSE NUMBER AND STATE **TELEPHONE NO**

As a Physician for the above-named patient, I hereby certify that I have examined the named applicant and I verify that this individual has a visual disability that meets the requirements for the special visual disability scope permit for muzzleloader or bow hunt, and that all information I am providing is true and correct.

PHYSICIAN'S SIGNATURE **DATE**

ADDITIONAL REQUIREMENT FOR OUT OF STATE PHYSICIANS

Physicians, Ophthalmologist, or Optometrists not licensed in the state of Nevada must send a photocopy of their medical license or have their signature notarized below.

Signed and sworn before me on this day of _____, 20____ before me, a Notary Public for the state of _____, residing in _____ county, the undersigned personally appeared known to me to be the person whose name is subscribed to the within instrument.

Notary Public

OFFICIAL
SEAL