Arizona Game and Fish Department 5000 W Carefree Hwy Phoenix, Arizona 85086 (602)942-3000 www.azgfd.gov	**For Department Use Only** Date Received _____Region_____ Approved Date _____Denied Date_____ Approved By_____
Permanent Permit_____	Temporary Permit Valid from _____to _____

Please Print or Type

*****Social Security Number is voluntary to be used for Sportsman's Database Only*****

Application for a Permanent/Temporary Crossbow Permit

Fee: Complimentary

The Arizona Game and Fish Department may issue a Crossbow permit to those who have one or more of the following physical limitations. An amputation involving body extremities required for stable function to use conventional archery equipment; A spinal cord injury resulting in a disability to the lower extremities, leaving the applicant nonambulatory; A wheelchair restriction; A neuromuscular condition that prevents the applicant from drawing and holding a bow; A failed functional draw test that equals 30 pounds of resistance and involves holding it for four seconds; A failed manual muscle test involving the grading of shoulder and elbow flexion and extension or an impaired range-of-motion test involving the shoulder or elbow; or A combination of comparable physical disabilities resulting in the applicant's inability to draw and hold a bow.

Name		**Date of Birth**	**Phone**	
Mailing Address		**City**	**State**	**Zip**
Physical Address		**Resident**	**Nonresident**	
Dept. ID/SSN	**Email**		**Champ Permit Number**	
Gender	**Height**	**Weight**	**Eyes**	**Hair**
Applicant Signature			**Date**	

It shall be unlawful for any person to obtain by fraud or misrepresentation a license to take wildlife. Such license fraudulently obtained shall be void from the date of issuance. I hereby certify that the above statements are true.

Health Care Provider Certification

I hereby certify that _____meets the requirements for a Crossbow Permit. **(Print Name)**

Indicate whether the disability is temporary or permanent and, when temporary, specify the expected duration of the physical limitation.

Permanent Disability_____

Temporary Physical Limitation from Date_____ To Date_____

Health Care Provider's Name_____
(Print Name)

License Number_____

Name of Medical Facility_____

Address of Medical Facility_____

City_____State_____Zip_____

Phone Number_____

Health Care Provider's Signature_____Date_____

Health Care Provider means a person who is licensed to practice by the federal government, any state, or U.S. territory with one of the following credentials: Medical Doctor, Doctor of Osteopathy, Doctor of Chiropractic, Nurse Practitioner or Physician Assistant.

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