ARKANSAS GAME AND FISH COMMISSION
MOBILITY IMPAIRED ACCESS PERMIT
2 NATURAL RESOURCES DRIVE
LITTLE ROCK, AR 72205

YOU MUST BE PERMANENTLY MOBILITY IMPAIRED IN ORDER TO OBTAIN A CARD

The Mobility Impaired Access Permit is issued Free-Of-Charge. There is a $2.00 fee to replace lost, stolen, or destroyed cards. After you have received a Mobility Impaired Access Permit, periodic re-qualification may be required.

THE CARD IS NOT A HUNTING/FISHING LICENSE; IT ENTITLES THE HOLDER TO SPECIAL ACCESS PRIVILEGES.

♦♦

FIRST NAME________________________________ MIDDLE INITIAL______ LAST NAME_______________________________________

MAILING ADDRESS____

CITY____ STATE____________________ ZIP CODE__________________

PHONE (_____)_________________________________ DATE OF BIRTH_________________________ SEX_________

EYE COLOR_____________ HEIGHT_____________ SOCIAL SECURITY # ____
(Required On All Applications)

SIGNATURE OF APPLICANT (OR LEGAL GUARDIAN)____

♦♦♦

PHYSICIAN'S CERTIFICATION – THIS APPLICANT IS OR HAS BEEN A PATIENT IN MY CARE AND IS **PERMANENTLY** MOBILITY IMPAIRED.

CHECK THE APPROPRIATE CONDITION:

☐ **1)** Cannot walk without the **permanent** use of: **(circle one)** a brace, cane, crutch, prosthetic device, wheelchair, or walker.

☐ **2)** Is **permanently** restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one (1) liter, or the arterial oxygen tension is less than (60) mm/hg on room air at rest.

☐ **3)** Has a **permanent** condition which requires the use of portable oxygen.

☐ **4)** Has a **permanent** cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by *The American Heart Association*.

DOCTOR'S NAME **(PLEASE PRINT OR TYPE)**____

MEDICAL LICENSE NUMBER AND STATE____

ADDRESS____ CITY___________________________

STATE___________________________ ZIP CODE_________________ PHONE(_____)_______________________

PHYSICIAN'S SIGNATURE____ DATE_____________________
(Rubber Stamp Not Acceptable)

Return The Completed Application To The Address Listed At The Top Of This Form.