Department of Fish & Wildlife Resources

1 Sportsman's Lane

Frankfort, Kentucky 40601

HUNTING METHODS EXEMPTION – CROSSBOW PERMIT

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE(\_\_\_)\_\_\_\_\_\_\_\_\_\_ ID#(SSN OR DRIVERS LICENSE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_

The following is to be filled out by a licensed physician.

I do hereby attest that the above named individual is not able to use conventional archery equipment and must use a crossbow because:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(description of disability)

This disability is temporary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or permanent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(length of time is required)

TERMS OF PERMIT

1. Once completed and signed this application will be your HUNTING METHODS EXEMPTION PERMIT.
2. The permit holder is authorized to use a crossbow during archery seasons.
3. The crossbow must conform to provisions of applicable regulations.
4. All other statutes and regulations must be observed.
5. Permit holder must possess appropriate KY hunting licenses and tags.
6. This permit must be carried on person.
7. If the disability is a temporary one this individual must return to conventional hunting methods at the end of the time specified above.
8. The Department of Fish and Wildlife does not maintain any copies of this permit. It is the responsibility of the user to maintain this document.
9. The Department of Fish and Wildlife does not assume any responsibility or liability for any activity conducted under this permit. The user assumes all risks and responsibilities.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of licensed physician Business address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name City State Phone Number

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and agree with to comply with all the above terms. Applicant Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Once this form is completed, please do NOT

return it to KDFWR.

THIS IS YOUR PERMIT