

State of West Virginia  
Division of Natural Resources  
**MODIFIED BOW PERMIT**

**Section I: This section to be completed by applicant.**

Name: \_\_\_\_\_  
*Last First Middle Initial*

Address: \_\_\_\_\_  
*Street, P.O. Box, Route, etc. City State Zip*

Social Security Number: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

I hereby certify under penalty of perjury that the information provided on this form is true to the best of my knowledge and belief, and that I have not failed to meet child support obligations as defined in WV Code §48-5A, and that I realize that making a false statement may result in loss of my license(s).

\_\_\_\_\_  
*Signature of Applicant Date*

**Section II: Authorization to Release Information.**

*(Must be completed and signed in order to be eligible for this permit.)*

I hereby authorize any West Virginia Natural Resources Police Officer bearing this release to obtain information, including medical records, regarding my impairment to use a modified bow. I execute this release with full knowledge and understanding that information released under the terms of this release is for the official use of the Division of Natural Resources (hereinafter, DNR). I hereby grant my consent for DNR to furnish such information to third parties in the course of DNR fulfilling its official responsibilities.

I authorize the physician listed below to release medical information regarding my impairment that requires me to use a modified bow. I hereby release said physician, the institution or establishment he or she represents, and its employees, agents and anyone else acting on its behalf, and the DNR and its employees, from any and all claims, liability or damages of any nature that may result from furnishing the information requested by DNR.

A copy of this authorization document shall be as valid as the original. This release will expire six months from the date signed.

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*

**Physician's Certification**

**Section III: This section may only be completed/signed by a licensed physician.**

I certify that the above named applicant requires the use of a modified bow in order to be able to participate in the outdoor sport of archery hunting. Describe the impairment that requires the use of a modified bow: \_\_\_\_\_

Is this impairment: Permanent?  Temporary?  (Valid from: \_\_\_\_\_ to \_\_\_\_\_)

Medical or DO License Number: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
*(Please Print)*

Address: \_\_\_\_\_  
*Street, P.O. Box, Route, etc. City State Zip*

I understand that furnishing false information for any license or permit may subject me to the penalties provided in the West Virginia Code, Chapter 20 [§20-7-9].

For DNR Use Only:  
H/F License Section # \_\_\_\_\_

\_\_\_\_\_  
*Physician's Signature*

\_\_\_\_\_  
*Date*

(Revised 12/11/2012)