



**DEPARTMENT OF WILDLIFE RESOURCES  
LIFETIME LICENSE SALES  
P.O. Box 2978  
HENRICO, VA 23228  
866-721-6911**

(Hearing impaired call TDD# 804-367-1278)

**Physician's Affidavit for a Permanent Disability for  
Disabled Lifetime Licenses and Treestand Exemption**

**NOTE: THIS FORM MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN**

If you need assistance, contact us at 1-866-721-6911 or for the hearing impaired TDD: 804 367-1278

I hereby swear, under penalty of perjury that I \_\_\_\_\_, am a licensed physician or  
(Physicians name-please print)  
 certified nurse practitioner for \_\_\_\_\_, and do hereby certify the applicant  
(Patients full name-please print)

herein named to be **Permanently** and **Totally** disabled as defined by Code of Virginia§ 58.1-3217:  
*Permanently and totally disabled defined-For purposes of this article, the term "permanently and totally disabled" shall mean unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or deformity which can be expected to result in death or can be expected to last for the duration of such person's life.*

By signing this statement I certify that the information provided below is true and correct and that I am currently a licensed physician in \_\_\_\_\_.  
(State-please print)

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Information** (please print):

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender:  Male  Female

An examination of the above named individual was conducted on \_\_\_\_\_.  
(Exam Date-please print)

**Provide a brief description of the permanent and total disability for this person below:**

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

**Physician Information** (please print):

Physician's Name: \_\_\_\_\_  
First Middle Initial Last Name

Name of Business/Practice: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_