DEPARTMENT OF GAME AND INLAND FISHERIES
LIFETIME LICENSE SALES
P. O. BOX 90778
HENRICO, VA 23228-0778
866-721-6911
(Hearing impaired call TDD# 804-367-1278)

Physician's Affidavit for a Disabled Lifetime License

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 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: _____