

# Disable Fishing Form

Take application to \_\_\_\_\_ your physician. A physician must fill out the physician statement and \_\_\_\_\_ sign. Return the completed application to the Probate Judge or License \_\_\_\_\_ Commissioner in your \_\_\_\_\_ county of residence. PRINT OR TYPE ONLY. Full Name: \_\_\_\_\_

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

Mailing Address (if different): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICIANS ONLY

(Excerpt of SECTION 9-11-54, CODE OF ALABAMA 1975) For the purpose \_\_\_\_\_ of this license the term "disabled" means inability to engage in any substantial \_\_\_\_\_ gainful activity by reason of any medically determinable physical impairment \_\_\_\_\_ which can be expected to result in death or in blindness or to be long continued and indefinite duration. The term "blindness" as \_\_\_\_\_ used in this section, means central visual acuity of 5/200 or less \_\_\_\_\_ in the better eye with the use of a corrective lens. An eye in which \_\_\_\_\_ the visual field is reduced to five degrees or less concentric contraction \_\_\_\_\_ shall be considered for the purposes of this section as having a \_\_\_\_\_ central visual acuity or 5/200 or less.

Type of Disability: \_\_\_\_\_

If Blindness: Visual Acuity: \_\_\_\_\_

Duration of Disability: \_\_\_\_\_

This is to certify that the applicant named above is totally disabled \_\_\_\_\_ as defined by section 9-11-54 Code of Alabama 1975.

Name of Physician: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_