SAVE PRINT CLEAR

State of California – Department of Fish and Wildlife

FREE SPORT FISHING LICENSE APPLICATION – DEVELOPMENTAL DISABILITY

SPORT FISHING LICENSES ARE VALID FOR 365 DAYS FROM THE DATE OF PURCHASE.

A free fishing license is available for any person who is developmentally disabled, pursuant to Section 7151(a)(3) of California Fish and Game Code. The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment that begins before an individual reaches adulthood (18 years of age). These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions closely related to intellectual disability or requiring similar treatment. For more information, visit the Department of Developmental Services website at: www.dds.ca.gov.

Applicant Instructions - To apply for a free fishing license, certification by a licensed physician or the Director of a State Regional Center is required (e.g., a letter on physician's letterhead certifying the applicant's developmental disability, and signed by a licensed physician). Submit this completed application with a certification letter from the Director of a State Regional Center or a licensed physician.

Licensed Physician or Director of State Regional Center Instructions - Complete the section indicated below and attach a letter certifying the applicant is developmentally disabled. The certification letter must be on your letterhead, contain your signature, and state that the applicant meets the eligibility criteria defined above. **Certification must be by a Director of a Regional Center or a licensed physician. Certification cannot be from a nurse practitioner or physician's assistant.**

You may mail your signed application, certification letter, and a photocopy of your state issued identification to:

Department of Fish and Wildlife
License and Revenue Branch
PO Box 944209
Sacramento, CA 94244-2090

OR

You may submit the required documents electronically by: requesting that a secure File Transfer Protocol (FTP) link be emailed to you so that you can upload your signed application, certification letter, and photocopy of your state issued identification to CDFW's secure FTP website. Request a secure FTP link by emailing LRB@wildlife.ca.gov.

All applications will be reviewed and eligibility will be verified prior to license issuance. Allow 15 business days for review and processing of your application. Incomplete or unsigned applications will be returned.

Any license fraudulently obtained will be revoked and any person committing fraud to obtain this license will be prosecuted.

APPLICANT INFORMATION

FIRST NAME	M.I.	LAST NAME	GO ID NUMBER (IF KNOWN)

MAILING ADDRESS

CITY	STATE	ZIP CODE

GENDER ☐ MALE ☐ FEMALE ☐ NONBINARY	HAIR COLOR	EYE COLOR	HEIGHT (Ft., In.)	WEIGHT	DATE OF BIRTH

METHOD OF RESIDENCY

☐ I have resided continuously in California for the last six months. ☐ I am not a resident of California

DAY TELEPHONE	E-MAIL ADDRESS (Voluntary)

APPLICANT CERTIFICATION

I certify under penalty of perjury that the information given on this application is true and correct to the best of my knowledge; that I have not been convicted of any Fish and Wildlife violation; and that I meet the qualifications for this license. I hereby authorize the Director of a Regional Center or physician below to release to California Department of Fish and Wildlife, verification of my developmental disability.

Digital Signature Certification (if a digital signature is used): With accordance to California Civil Code §1633.5(b), I acknowledge that by providing my electronic signature for this form, I agree that my electronic signature is the legal binding equivalent to a handwriting signature. I hereby confirm that my electronic signature represents my execution or authentication of this form, and my intent to be bound by it.

SIGNATURE	DATE
X	

THIS SECTION MUST BE FILLED OUT BY A LICENSED PHYSICIAN OR STATE REGIONAL CENTER (A Nurse Practitioner or Physician's Assistant cannot certify this application in place of a licensed physician.)

NAME AND TITLE OF CERTIFYING OFFICIAL	
PHYSICIAN LICENSE NUMBER OR NAME OF STATE REGIONAL CENTER	CERTIFYING OFFICIAL'S TELEPHONE NUMBER
CERTIFYING OFFICIAL'S ADDRESS	

CITY	STATE	ZIP CODE

Digital Signature Certification (if a digital signature is used): With accordance to California Civil Code §1633.5(b), I acknowledge that by providing my electronic signature for this form, I agree that my electronic signature is the legal binding equivalent to a handwriting signature. I hereby confirm that my electronic signature represents my execution or authentication of this form, and my intent to be bound by it.

CERTIFYING OFFICIAL'S SIGNATURE

X