ARIZONA GAME AND FISH DEPARTMENT

5000 W. CAREFREE HIGHWAY • PHOENIX, AZ 85086

CHAMP PERMIT APPLICATION R12-4-217 • EFFECTIVE 7/1/2026

FOR DEPARTMENT USE ONLY

Date Received: _____ Region: _____

Date: _____ ☐ Approved ☐ Denied CSR Initials: _____

Permit Number: _____ Approved By: _____ RS/LEPM/OM Date: _____

Fee: $13 Resident (Class Code 7834) / $15 Non-Resident (Class Code 7835)

The Arizona Game and Fish Department may issue a CHAMP Permit to those who have a severe permanent disability. "Severe permanent disability" means one or more physical or mental disabilities resulting from amputation of both upper and lower limbs, permanent use of wheelchair, crutches, or a walker, arthritis, autism, blindness, extensive burn injury, cancer, cerebral palsy, cystic fibrosis, intellectual disability, muscular dystrophy, musculoskeletal disorders, neurological disorders, paraplegia, pulmonary disorders, quadriplegia and other spinal cord conditions, sickle cell anemia, and end stage renal disease or a combination of permanent disabilities resulting in comparable substantial life function limitations.

Please complete this form by typing or printing clearly.

Customer ID Number: _____ Date of Birth: _____

Legal Name: _____ Phone Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____ Hair Color: _____

Gender: _____ Weight: _____ Height: _____ Eye Color: _____

☐ Resident Date of Residency: _____ (month, day, year)
☐ Non-Resident

Physical Address (if different than mailing): _____

Email: _____

Applicant's Signature: _____ Date _____

It is unlawful for any person to obtain by fraud or misrepresentation a license to take wildlife. Any license fraudulently obtained is void from the date of issuance. By signing this document I affirm that I meet the eligibility requirements of this rule and the information provided on the application is true and accurate.

Qualified Physician Certification

I hereby certify that _____ meets the requirements for a CHAMP permit and that I am a Qualified Physician as defined in Rule R12-4-217.

Per R12-4-217 "Qualified Physician" means a currently licensed and board-certified medical or osteopathic physician (M.D. or D.O. only) who has an unrestricted license to practice medicine in any U.S. state or U.S. territory. Physician shall primarily practice or specialize in disorders, diseases or conditions that cause a severe permanent disability as that term is defined in the section at the top of this form.

Qualified Physician's Name: _____ **Must indicate:** (M.D. or D.O. only) ☐ **M.D.** ☐ **D.O.**

License Number: _____

Name of Medical Facility: _____ Phone Number: _____

Address of Medical Facility: _____

City: _____ State: _____ ZIP Code: _____

Qualified Physician's Signature*: _____ Date: _____

*By signing, the Qualified Physician acknowledges and understands that a knowingly false or fraudulent submission may result in a complaint of unprofessional conduct to the appropriate medical board.

Si desea hablar con un representante de servicio al cliente bilingüe para obtener información llame al 602-942-3000 de lunes a viernes de 8:00 a.m. a 5:00 p. y luego ingrese el número 5 durante el mensaje grabado.