



# APPLICATION CERTIFICATE OF REGISTRATION TELESCOPIC SIGHT

**Attention: False, inaccurate, or misleading information** on this application is a **criminal offense** and **violation** of Utah Code Title 23 Chapter 19 Section 5

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R657-12-9. Telescopic Sights.

- (1) A person who has a permanent vision impairment leaving them with worse than 20/40 corrected visual acuity in the better eye may receive a Certificate of Registration to use telescopic sights; if in the professional opinion of the eye care provider telescopic sights will sufficiently mitigate the effects of the disability to enable the person to:
  - (a) adequately discern between lawful and unlawful wildlife species and species genders; and
  - (b) safely discharge a firearm or bow in the field.
- (2) A person with qualified vision impairment may obtain a Certificate of Registration from the Division to use telescopic sights by submitting a signed statement by a licensed ophthalmologist, optometrist or physician verifying that:
  - (a) the applicant has a permanent vision impairment resulting in worse than 20/40 corrected visual acuity in the better eye; and
  - (b) telescopic sights will sufficiently mitigate the effects of the vision impairment to enable the applicant to:
    - (i) adequately discern between lawful and unlawful wildlife species and species genders; and
    - (ii) safely discharge a firearm or bow in the field.

**As the applicant I have read and understand the requirements for obtaining this Certificate of Registration**

Certificate of Registration is issued upon receipt and approval of application, and applicant's purchase of the required license/permit/tag.

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**I HEREBY APPLY FOR A CERTIFICATE OF REGISTRATION IN ACCORDANCE WITH THE ABOVE STIPULATIONS**

Customer Identification # \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_

I hereby certify under oath that the above information is true and correct, that I am eligible to obtain this Certification of Registration in accordance with the stipulations of Rule R657-12, under **Telescopic Sight**.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

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**PHYSICIAN'S STATEMENT**

(Must be completed and signed by physician, ophthalmologist, or optometrist)

I hereby certify the above named applicant meets the criteria for use of telescopic sights and that the following information is true and correct.

1. The applicant has worse than 20/40 corrected visual acuity in the better eye?:  Yes  No

2. Telescopic sights will sufficiently mitigate the effects of the disability to enable the applicant to adequately discern between lawful and unlawful wildlife species and species genders?:

Yes  No

3. Telescopic sights will sufficiently mitigate the effects of the disability to enable the applicant to safely discharge a firearm or bow in the field.?:  Yes  No

4. The applicant's vision impairment is permanent?:  Yes  No

Please explain how the impairment satisfies the state requirement found on page 1 of this application: (attach additional pages as necessary)

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

Dr. Office Use Only:

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Professional Title \_\_\_\_\_

Physician Name (print) \_\_\_\_\_ Telephone Number \_\_\_\_\_

Affix Office Stamp Here: Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Division Use Only:

Applicant meets the qualifications for this COR  Y  N  Need more information

Region \_\_\_\_\_ Date: \_\_\_\_\_ Clerk Initials: \_\_\_\_\_

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For more information or additional consideration please contact: Brad Vaske (801) 538-4815

Fax to: (801) 538---4858

Mail originals to: Attention Licensing  
1594 West North Temple Suite 2110  
Salt Lake City UT, 84114

\*You must provide the original documentation prior to being issued a C.O.R. You may bring this to any division office.