

THE FOLLOWING IS TO BE COMPLETED BY A LICENSED PHYSICIAN/CHIROPRACTIC PHYSICIAN/APRN/PA:

Please print or stamp clearly. If not legible, the application will not be accepted.

Physician/Chiropractic Physician/APRN/PA/ Name: _____

Address: _____
(Street, PO Box, or Route) City State Zip

Title: _____ Telephone: _____ Fax: _____

1. After administering the pinch, grip and nine-hole peg tests on _____, 20____, it is my opinion that: [Check One]

the applicant has a **PERMANENT AND SUBSTANTIAL** loss of function in one or both hands while **FAILING** to meet the minimum standards of the upper extremity pinch, grip, and nine-hole peg tests;

the applicant **DOES NOT** have a permanent or substantial loss of function in one or both hands and **DOES NOT** fail to meet the minimum standards of the upper extremity pinch, grip, and nine-hole peg tests.

2. After administering the shoulder strength test on _____, 20____, it is my opinion that: [Check One]

the applicant has a **PERMANENT AND SUBSTANTIAL** loss of function in one or both shoulders while **FAILING** to meet the minimum standards of the shoulder strength test;

the applicant **DOES NOT** have a permanent or substantial loss of function in one or both shoulders and **DOES NOT** fail to meet the minimum standards of the shoulder strength test.

Pursuant to results obtained from administration of the pinch, grip and nine-hole peg tests and/or the shoulder strength test, **I do hereby swear and affirm, under penalty of law, that I have personally examined the above named individual, and that the information herein is true and accurate to the best of my knowledge.**

Physician/Chiropractic Physician/APRN/PA/ Signature

Date

Print Physician/Chiropractic Physician/APRN/PA/ License Number and State of Issue

Applicant Signature

Date

Print Applicant Name

Send completed application with original signatures to:
West Virginia Division of Natural Resources
ATTN: License Section
324 Fourth Avenue
South Charleston WV 25303-1228

DNR-CR-Y1_10/16/2019