Department *of* Public Safety

State of Utah
Department of Public Safety
VOLUNTARY TEMPORARY FIREARMS RESTRICTION

INSTRUCTIONS

Requester Instructions

1. Print Request for Voluntary Temporary Firearm Restriction List (this form)
2. Please fill out all fields marked "Requester Information" on the form on the following page.
3. Select which restricted list you wish to be added to.
    a. Time-limited (180 days)
        i. May request removal 30 days after inclusion. You will be removed 3 business days after request is submitted.
    b. Indefinite
        i. May request removal 90 days after inclusion. You will be removed 3 business days after request is submitted.
4. Be sure to sign the acknowledgement at the bottom of the form.
5. Your health care provider will fill out the remainder of the form and transmit the form for you.

Extension/Removal From Voluntary Temporary Firearm Restriction List

1. After 180 days, removal from the Time-Limited Restriction list is automatic. If you wish to remain on the list for longer than 180 days, please request a 180-day extension using this form. An extension may be requested at any Utah law enforcement agency.
2. If you wish to be removed from the Voluntary Temporary Firearm Restricted List prior to 180 days, you will need to submit a Request for Removal From The Voluntary Temporary Firearm Restriction List found on bci.utah.gov. Note that if you wish to be removed from the temporary restriction list, you must wait at least 30 days. Early removal from the indefinite list may be requested after 90 days.

Health Care Provider (HCP) Instructions

1. Verify the requester's identity.
2. Complete "Health Care Provider" section of the form, including the Health Care Provider statement.
3. Scan and email the form to dpscic@utah.gov.
4. Retain the original form for your records.
5. If an extension is not requested, all forms and copies of forms must be destroyed within five days of automatic removal from the Voluntary Temporary Firearms Restricted List.
6. If early removal from the Voluntary Temporary Firearms Restricted List is requested, all forms must be destroyed within five days of removal.

State of Utah
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REQUEST FOR INCLUSION IN THE VOLUNTARY TEMPORARY FIREARMS RESTRICTION LIST

Please read all instructions on the previous page prior to completing this form.

Requester Information

Name_____ Date of Birth _____
(Last) (First) (Middle)
(Please print full name as it appears on your driver license or state issued ID card)

Previously used Name(S)(Maiden, etc.)_____

Physical Address_____
(Street) (City) (County) (State) (Zip)

Daytime Phone# _____Alt Phone #_____

Initial by the restriction list you wish to be added to, then sign the corresponding statement below.

_____ Time-limited (You can request removal after 30 days. You will be automatically removed after 180 days)

_____ Indefinite (you can request removal after 90 days. You will not be automatically removed.)

Time Limited Restriction Statement:

By presenting this completed form to a law enforcement agency *or health care provider*, I understand that I am requesting that my name be placed on a list that restricts my ability to purchase or possess firearms for a minimum of 30 days, and up to 6 months. I understand that by voluntarily making myself a temporarily restricted person, I may not have a firearm in my possession and any attempt to purchase a firearm while I am on the list will be declined. I also understand that any time after 30 days, I may request removal from the temporary restricted list and all previous rights will be restored.

In addition, if I am in possession of a valid concealed firearm permit, my permit will be suspended during the time I am on the list, but will be reinstated upon my removal unless the permit has expired, been revoked, been suspended for another reason, or I become ineligible to possess a firearm. Additionally, I acknowledge that if I possess a firearm or attempt to purchase a firearm while outside Utah, I will be subject to the law of that location regarding restricted persons.

By presenting this completed form to my health care provider, I understand that I am requesting that my health care provider present my name to the Bureau of Criminal Identification to be placed on a restricted list that restricts my ability to purchase or possess firearms.

Signed on: _____ _____
(Date) (Applicant Signature)

Indefinite Restriction Statement:

By presenting this completed form to a law enforcement agency *or health care provider*, I understand that I am requesting that my name be placed on a restricted list that restricts my ability to purchase or possess firearms indefinitely. I understand that by voluntarily making myself a temporarily restricted person, I may not have a firearm in my possession and any attempt to purchase a firearm while I am on the restricted list will be declined. I also understand that any time after 90 days, I may request removal from the restricted list and all previous rights will be restored.

In addition, if I am in possession of a valid concealed firearm permit, my permit will be suspended during the time I am on the restricted list, but will be reinstated upon my removal, unless the permit has expired, been revoked, been suspended for another reason, or I become ineligible to possess a firearm. Additionally, I acknowledge that if I possess a firearm or attempt to purchase a firearm while outside Utah, I will be subject to the law of that location regarding restricted persons. By presenting this completed form to my health care provider, I understand that I am requesting that my health care provider present my name to the Bureau of Criminal Identification to be placed on a restricted list that restricts my ability to purchase or possess firearms.

Signed on: _____ _____
(Date) (Applicant Signature)

Health Care Provider Information & Statement

Health Care Provider Name (please print)_____

Organization _____

License/Certification Number_____

By presenting this completed form to the Bureau of Criminal Identification, I understand that I am acknowledging that I have verified the identity of [name of individual seeking inclusion on a restricted list] and have witnessed [name of individual] sign the form requesting that [name of individual] be placed on a restricted list that restricts [name of individual]'s ability to purchase or possess firearms. I affirm that [name of individual] is currently my patient, and I am a licensed health care provider acting within the scope of my license, certification, practice, education, or training.

Signed on: _____ _____

(Date) (Health Care Provider Signature)