PERSON WITH A DISABILITY PARKING PERMIT APPLICATION

STATE OF HAWAII
DISABILITY AND COMMUNICATION ACCESS BOARD

Applicant must present proof of identity. All forms of identification shall be current or valid. Acceptable forms of identification include: driver's license, state ID, passport, senior citizen ID, military ID, student ID, ID of a parent or guardian of a minor, Medicare card; notarized affidavit from: a Hawaii State or county social service agency, the administrator of a Hawaii State or privately owned nursing home, the spouse, an adult relative, a friend, an assistant, the verifying physician or verifying advanced practice registered nurse.

FOR OFFICIAL USE ONLY

1st Placard # _____

2nd Placard # _____

Expiration Date _____

License Plates # _____

FEES COLLECTED, IF APPLICABLE:

Amount Collected $ _____

× _____
Clerk's Initials Date

1. APPLICANT'S NAME

LAST

FIRST M.I.

2. PHONE NO. ☐☐☐☐☐☐☐☐☐☐ **3. BIRTH DATE** (00 / 00 / 0000) ☐☐ MONTH / ☐☐ DAY / ☐☐☐☐ YEAR

4. HEIGHT ☐☐ FEET / ☐☐ INCHES **5. WEIGHT** ☐☐☐ POUNDS **6. GENDER** ❑ Male ❑ Female

7. STREET ADDRESS

STREET

APT.#

CITY STATE ☐☐☐☐☐-☐☐☐☐ ZIP CODE

8. MAILING ADDRESS

STREET

APT.#

CITY STATE ☐☐☐☐☐-☐☐☐☐ ZIP CODE

9. INDICATE THE COUNTY WHERE YOU LIVE

❑ City & County of Honolulu ❑ County of Hawaii ❑ County of Kauai ❑ County of Maui

10. PARKING PLACARD REQUEST (Switching from a temporary placard to a permanent placard is considered a first time application)

Mark applicable box and enter serial number of placard(s) last issued. I am requesting a:

❑ **First** Time Hawaii placard

❑ **Renewal** of my Hawaii placard(s) placard #(s) ☐☐☐☐☐☐☐;☐☐☐☐☐☐☐

❑ **Replacement** placard #(s) ☐☐☐☐☐☐☐;☐☐☐☐☐☐☐

11. COMPLETE ONLY IF REQUESTING SPECIAL LICENSE PLATES (Applying for a special plate cannot be done by mail)

❑ I am interested in receiving information on how to apply for special license plates at the Satellite City Hall or County issuing site.

❑ I am requesting special license plates. I am the registered owner of the vehicle on which the special license plates will be affixed, **AND** the vehicle will be used primarily to transport me.

Year of Vehicle ☐☐☐☐ Make ☐☐☐☐☐☐☐☐☐☐ Model ☐☐☐☐☐☐☐☐☐☐

Vehicle Lic. # ☐☐☐☐☐☐ Registration Expiration Date (Month) ☐☐ / (Year) ☐☐

12. TERMS TO RELEASE OF MEDICAL INFORMATION

I declare, under the penalties of the penal law, that the statements contained herein are, to the best of my knowledge and belief, true and accurate and that I have not knowingly and willingly made a false statement or given information which I know to be false in connection therewith. I also authorize my physician to release medical information necessary to process this application.

× _____ _____
APPLICANT'S SIGNATURE (or Authorized Representative) DATE

CERTIFICATION BY LICENSED PRACTICING PHYSICIAN/APRN

This page must be completed by a licensed practicing physician (as defined under HRS §§453, 455, 460, and 463E), or an advanced practice registered nurse (as defined under HRS §457.8.6).

CERTIFICATION OF CONDITION The physician or an advanced practice registered nurse must certify that the applicant has one or more of the specific disabilities listed below (as defined under HRS §291-51). A list of conditions that do not qualify an applicant can be found on the web: http://health.hawaii.gov/dcab.

I certify that _____ **meets at least one of the criteria below.**
APPLICANT'S NAME

13. MARK APPROPRIATE BOX(ES). ONLY ONE CATEGORY IS REQUIRED.

(a) The applicant is **UNABLE TO WALK** 200 feet without stopping to rest due to the following condition:

❑ Arthritic ❑ Neurologic ❑ Orthopedic ❑ Oncologic ❑ Renal ❑ Vascular

(b) The applicant is diagnosed with the following **RESPIRATORY DISABILITY**:

❑ **FEV < 1L** - Forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter.

❑ **P_3O_2 < 60 mm. Hg** - Arterial oxygen tension is less than sixty mm/hg on room air at rest.

(c) The applicant is diagnosed with the following **HEART CONDITION** according to the American Heart Association Standards:

❑ **Class III** - Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.

❑ **Class IV** - Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

(d) The applicant is **UNABLE TO WALK** without the use of, or assistance from, the following:

❑ Artificial Lower Limb(s) ❑ Brace(s) ❑ Crutches ❑ Walker ❑ Cane(s) (excluding white canes)

❑ Another Person ❑ Wheelchair ❑ Other Assistive Device (specify): _____

(e) ❑ The applicant **USES PORTABLE OXYGEN**.

14. DURATION OF DISABILITY

❑ Temporary Disability for a duration of:
(**Mark one box only**. If the disability lasts longer than anticipated, subsequent certification can be made.)

❑ 1 month ❑ 2 months ❑ 3 months ❑ 4 months ❑ 5 months ❑ 6 months

OR

❑ Long-term Disability

15. NOT ABLE TO APPLY IN PERSON (Mark only if applicable)

❑ The applicant is physically unable to apply in person due to a medical condition. ×_____
PHYSICIAN'S/APRN'S SIGNATURE

16. PHYSICIAN or ADVANCED PRACTICE REGISTERED NURSE READ CAREFULLY I understand that per HRS §291 Part III, as a physician/advanced practice registered nurse (APRN), fraudulently verify that to obtain a parking permit, I shall be guilty of a petty misdemeanor, and each fraudulent verification shall constitute a separate offense. For program integrity, DCAB conducts random checks to verify the authenticity of certifications.

a. PHYSICIAN'S/APRN'S NAME (PRINT OR TYPE) _____ LAST _____ FIRST ____ M.I.

b. MAILING ADDRESS (PRINT OR TYPE) _____ STREET / P.O. BOX HAWAII _____ CITY 96_____ ZIP CODE

c. PHONE NO. (808) _____

d. PHYSICIAN'S/APRN'S SIGNATURE ×_____ **M.D. / N.D. / D.O. / D.P.M. / APRN** (CIRCLE ONE)

MEDICAL LIC. NO. _____
(HAWAII / U.S. ARMED SERVICES STATIONED IN HAWAII)

e. DATE _____ / _____ / _____
MONTH DAY YEAR

FOR PROCESSING, APPLICANT MUST SUBMIT THIS FORM TO THE APPROPRIATE ISSUING AGENCY.
First-time placards (blue in color) and **temporary placards** (red in color) are processed in person at a Satellite City Hall or County issuing site.
Replacement placards (lost, stolen, or mutilated) are processed in person at a Satellite City Hall or County issuing site for a fee.
Long-term placard renewals (blue in color) are processed by mail: DCAB, 919 Ala Moana Blvd., Rm. 101, Honolulu HI 96814
Application form can be found on the DCAB website: http://health.hawaii.gov/dcab.