PERSON WITH A DISABILITY PARKING PERMIT APPLICATION
LONG TERM PLACARD (BLUE) RENEWAL

STATE OF HAWAII
DISABILITY AND COMMUNICATION ACCESS BOARD

This form must be submitted by mail to P.O. Box 3377, Honolulu, HI 96801. Side 1 to be completed by the applicant, side 2 to be completed by the verifying physician or advanced practice registered nurse. If you legally changed your name since the last time you applied for a parking permit, please list your prior name here:

_____

FOR OFFICIAL USE ONLY

Placard # _____

Expiration Date _____

License Plates # _____

X_____
Clerk's Initials Date

1. APPLICANT'S NAME

_____
LAST

_____ _____
FIRST MIDDLE INITIAL

2. PHONE NUMBER _____ **2a. EMAIL** _____
(xxx) xxx-xxxx (optional)

3. BIRTH DATE _____ **4. HEIGHT** _____ **5. WEIGHT** _____ **6. GENDER** ☐ Male ☐ Female
(mm/dd/year) (Feet, Inches) (Pounds)

7. RESERVED. 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. ☐ I am renewing my long term parking placard. Current placard # P_____

11. SPECIAL LICENSE PLATES (Applying for special plates cannot be done by mail)
☐ I am interested in receiving information on how to apply for special license plates at the County issuing site.
☐ I currently have special license plates. #DP_____

Year of Vehicle _____ Make _____ Model _____

Vehicle Lic. # _____ Vehicle Registration Expiration Date _____
(mm/dd/year)

12. DECLARATION AND AUTHORIZATION TO RELEASE 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 or advanced practice registered nurse to release medical information necessary to process this application.

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

SUBMIT THIS FORM BY MAIL TO:
DCAB
P.O. BOX 3377
HONOLULU, HI 96801

CERTIFICATION BY LICENSED PRACTICING PHYSICIAN/APRN
FOR DISABILITIES EXPECTED TO LAST A MINIMUM OF SIX (6) YEARS

This page must be completed by a licensed practicing physician (as defined under HRS §§453, 455, 460, or 463E) or an advanced practice registered nurse (as defined under HRS §457).

CERTIFICATION OF CONDITION: The physician or advanced practice registered nurse (APRN) must certify that the applicant has one or more of the specific disabilities listed below (as defined under HRS §291-51). The list of conditions that do not qualify includes blindness; deafness; upper limb amputation; mental illness; old age; pregnancy; infancy; and learning, intellectual or developmental disabilities.

13. CRITERIA. I certify that _____ meets one or more of the criteria below:
(APPLICANT'S NAME)

(a) The applicant is **UNABLE TO WALK** 200 feet without stopping to rest due to the following condition:
☐ Arthritic ☐ Neurological ☐ 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: ☐ Long term disability expected to last a minimum of six years.

15. APPLICANT IS UNABLE TO APPLY IN PERSON (Mark only if applicable)

☐ I certify that this applicant is physically unable to apply in person due to a medical condition. _____
(PHYSICIAN'S/APRN'S SIGNATURE)

16. PHYSICIAN/APRN CERTIFICATION. I understand that per HRS §291-51.4, a physician/APRN, who fraudulently verifies that the applicant is qualified for purposes of this form shall be guilty of a petty misdemeanor and each fraudulent verification shall constitute a separate offense. DCAB conducts random checks to verify the authenticity of certifications.

a. **PHYSICIAN'S/APRN'S NAME** _____ _____ _____
(PRINT OR TYPE) LAST FIRST MI

b. **MAILING ADDRESS** _____ _____ HI 96_____
(PRINT OR TYPE) STREET/PO BOX CITY ZIP CODE

c. **PHONE NUMBER** (808) _____

d. **PHYSICIAN'S/APRN'S SIGNATURE** *x* _____

MEDICAL LIC. NO. M.D. / N.D. / D.O. / D.P.M. / APRN (circle one) #_____
(HAWAII OR U.S. ARMED SERVICES STATIONED IN HAWAII)

e. **DATE** _____ /_____/_____
MONTH DAY YEAR

For more information, call (808) 586-8121 or visit http://health.hawaii.gov/dcab/.