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 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 MI

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 (1) has a disability that limits or impairs the ability to walk and (2) has one or more of the specific disabilities listed under item 13 below (as defined under HRS §291-51). Individuals who belong to any of the following classes do not qualify for a permit solely on that status: persons who have a visual impairment; persons who have a mental illness; persons who are old; persons who are infants; persons who are deaf; persons who have an upper limb amputation; persons who are pregnant; and persons who have a behavioral, learning, intellectual, or developmental disability.

13. I certify that _____ has a disability that limits or impairs the ability to walk and
Applicant's Name

(a) The applicant **CANNOT WALK** (under their own power) 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 **CANNOT WALK** (under their own power) 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. (Use form PA-1 if less than 6 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, or to obtain form PA-1, call (808) 586-8121 or visit http://health.hawaii.gov/dcab/.

PERSON WITH A DISABILITY PARKING PERMIT APPLICATION FORM INSTRUCTION SHEET

Use Form PA-2 to apply for Long Term Placard (Blue) Renewal

SIDE 1 – TO BE COMPLETED BY APPLICANT

1. **APPLICANT'S NAME.** Print or type your name, beginning with your last name, then first name, and then middle initial.
2. **PHONE NUMBER.** Print your telephone number. If you do not have a telephone number, write "NONE."

2a. EMAIL. Enter your email address if you have one. This is optional. DCAB will use it ONLY to contact you for parking program purposes.

3. **BIRTH DATE.** Print the month, then day, then year. Example: If your date of birth is June 30, 1965, you would print 06/30/1965.
4. **HEIGHT.** Print your height in feet and inches.
5. **WEIGHT.** Print your weight in pounds.
6. **GENDER.** Mark the box for either Male or Female.
7. **RESERVED.**
8. **MAILING ADDRESS.** Print your mailing address.
9. **INDICATE THE COUNTY WHERE YOU LIVE.** Answer only if you live in Hawaii. Mark the box next to the county in which you live. Mark one box only.
10. Mark this box if you are applying for a **long term placard (blue) renewal**. Print the serial number of your expiring or expired long term placard in the space provided. Check your ID card for your placard number. There is no fee to renew your long term placard.
11. **SPECIAL LICENSE PLATES.** Mark the first box only if you want information about applying for special license plates. Mark the second box if you already have special license plates and enter the vehicle information.
12. **DECLARATION AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION.** Read the information carefully. This is your statement that you understand the terms of using the placard or special license plates. Sign and date the statement. If you are unable to sign due to your disability, your authorized representative may sign on your behalf.

SIDE 2 – TO BE **COMPLETED BY A PHYSICIAN OR ADVANCED PRACTICE REGISTERED NURSE ONLY IF SIDE 1 IS COMPLETED FIRST**

13. **CRITERIA**. Mark one or more of the qualifying conditions. The following conditions **do not** qualify: blindness; deafness; upper limb amputation; mental illness; old age; pregnancy; infancy; behavioral, learning, intellectual or developmental disabilities.
14. **DURATION OF DISABILITY.** Mark here if the qualifying condition is expected to last a minimum of six years. If it is expected to last less than six years, do not sign this form. Inform applicant they must submit **Form PA-1 First Time, Temporary, and Replacement Placards**.
15. **UNABLE TO APPLY IN PERSON.** Mark if the applicant is unable to apply in person due to a medical condition.
16. **PHYSICIAN / APRN SIGNATURE AND CERTIFICATION.** Input the following information:
    a) Physician/APRN name.
    b) Physician/APRN mailing address.
    c) Physician/APRN phone number.
    d) Physician/APRN signature (digital signature is acceptable).
    Circle medical license type (only listed types are accepted).
    Input medical license number (must be a Hawaii license unless military stationed in Hawaii).
    e) Date that the Physician/APRN signs the application.

WHERE TO SUBMIT THE COMPLETED APPLICATION

For all Form PA-2 – Renewal of Long Term (Blue) Placard Applications: Mail application form to:

DCAB
P.O. Box 3377
Honolulu, HI 96801