PERSON WITH A DISABILITY PARKING PERMIT APPLICATION FORM INSTRUCTION SHEET (FORM PA-3)

SIDE 1 – TO BE COMPLETED BY APPLICANT

1. **APPLICANT INFORMATION.** Print or type your name, beginning with your first name, middle initial, then last name. Only include a suffix (Jr., Sr., III, etc.) if applicable.
2. **PHONE NUMBER.** Print your telephone number, including the area code. If you do not have a telephone number, write "NONE."
3. **EMAIL ADDRESS.** Enter your email address if you have one. This is optional. DCAB will use it ONLY to contact you for parking program purposes.
4. **DATE OF BIRTH.** Print the month, day and year. Example: If your date of birth is June 30, 1965, you would print 06/30/1965.
5. **HEIGHT.** Print your height in feet and inches.
6. **WEIGHT.** Print your weight in pounds.
7. **GENDER.** Mark the box for either Male, Female, or X.
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 where you reside. Mark one box only.
10. **PARKING PLACARD REQUEST.** Mark the box next to the type of placard you are requesting.
    - **First time application.** Mark this box if this is the first time that you are applying for a temporary (red) placard, long term (blue) placard, Disability Paid Parking Exemption Permit/DPPEP (green) placard, or special license plates. A temporary (red) placard will be valid for no more than 6 months. There is a $12 fee for a temporary (red) placard. There is no fee for a first time long term (blue) placard or a first time DPPEP (green) placard.
    - **Second placard.** Mark this box if you want a second temporary (red) placard. A second temporary (red) placard is an additional placard that has the same expiration date as its companion placard. There is a $12 fee for a second temporary (red) placard.
    - **Renewing placard.** Mark this box to renew your temporary (red) placard, long term (blue) placard, or Disability Paid Parking Exemption Permit/DPPEP (green) placard. You may apply up to 60 days before it expires. The new expiration date will be calculated from the date the form is processed, so you may choose to wait until 30 days prior to expiration or later to submit the form. Print the placard number of your expiring or expired placard(s) in the space provided. Check your blue I.D. card for your placard number(s). If you currently have two temporary (red) placards and want two renewal temporary (red) placards, enter the placard number of each expiring or expired placard in the spaces provided. There is a $12 fee for renewing each temporary (red) placard. There is no fee to renew a long term (blue) placard or Disability Paid Parking Exemption Permit/DPPEP (green) placard. YOU MUST ALSO HAVE YOUR DISABILITY RECERTIFIED BY A LICENSED PRACTICING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE (APRN).
    - **Replacing a confiscated, lost, stolen, or mutilated** temporary (red) placard or long term (blue) placard. Mark this box if your temporary (red) placard or long term (blue) placard was confiscated, lost, stolen, or mutilated and is still valid. Print the placard number(s) in the space provided. Check your blue I.D. card for the placard number(s). There is a $12 fee for replacing a confiscated, lost, or stolen temporary (red) placard or long term (blue) placard. There is no fee for replacing a mutilated placard, but you must bring in its remaining parts, otherwise, it will be treated as replacing a lost placard and a $12 fee will apply. Side 2 of the form should be left blank.
    - **Replacing a confiscated, lost, or stolen** Disability Paid Parking Exemption Permit/DPPEP (green) placard. Mark this box if your DPPEP (green) placard was confiscated, lost, or stolen and is still valid. Print the placard number in the space provided. Check your blue I.D. card for the placard number. The replacement fees are as follows: first replacement $30, second replacement $60, third replacement $90, and any subsequent replacement $120. Side 2 of the form should be left blank.
    - **Replacing a mutilated** Disability Paid Parking Exemption Permit/DPPEP (green) placard. There is no fee for replacing a mutilated DPPEP (green) placard that is still valid. You must mail in its remaining parts, otherwise, it will be treated as replacing a lost placard and a fee will apply. Side 2 of the form should be left blank.
11. **(OPTIONAL) SPECIAL LICENSE PLATES REQUEST.** Mark only if requesting Special License Plates. You must provide information where indicated. You may obtain one set of plates and one long term (blue) placard or one Disability Paid Parking Exemption Permit/DPPEP (green) placard.
12. **(REQUIRED) 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, AMD, OR APRN ONLY IF SIDE 1 IS COMPLETED FIRST

13. (Required) CERTIFICATION OF CONDITION. To qualify for a disability parking permit, the physician or Advance Practice Registered Nurse (APRN) must certify that the applicant has a disability that limits or impairs the ability to walk 200 feet without stopping to rest and has been diagnosed with at least one of the conditions listed in (A) **AND** at least one of the functional impacts of the condition in (B).
Do not provide certification unless at least one condition listed in (A) and at least one condition listed in (B) is true as it pertains to the applicant.
NOTE: Under (B), certifying that the applicant cannot walk 200 feet without stopping to rest means the applicant cannot walk 200 feet under the applicant's own power without stopping to rest.

The following conditions do not qualify- visual impairments; mental illness; old age; infancy; deafness; upper limb amputation; pregnancy; behavioral, learning, intellectual or developmental disabilities.

14. (Required) DURATION OF DISABILITY. Mark the box that corresponds to the expected duration of the qualifying disability. If the expected duration is less than six years, mark the box next to the month of the expected duration on the Temporary line. Subsequent certifications can be made if the disability lasts longer than six months. If the disability is expected to last a minimum of six years, mark the 6 years box on the Long Term line.

15. (Optional) UNABLE TO APPLY IN PERSON. Mark **only** if the applicant is unable to apply in person due to a medical condition.

16. (Required) PHYSICIAN/APRN CERTIFICATION. Input the following information:

- Print physician‘s/APRN‘s full name, phone number and mailing address.
- Input medical license number (must be a Hawaii license unless military stationed in Hawaii).
- Circle medical license type (only listed types are accepted).
- Signature and date (apply to date of certification). A digital signature is accepted. A fax or photo copy of the physician‘s/APRN‘s signature will **NOT** be accepted.
- Signature is valid for 60 days (temporary placard) or 180 days (long term).

17. (Optional) CERTIFICATION FOR DISABLED PAID PARKING EXEMPTION PERMIT/DPPEP.
Certification is appropriate under this section only if the applicant has (1) a valid driver‘s license and (2) one of the three conditions listed is true as it pertains to the applicant. **Do not certify if the applicant does not qualify. If certifying the applicant for a DPPEP, full completion of sections 16 and 17 is required.**

RETURN COMPLETED ORIGINAL FORM BACK TO APPLICANT. YOU MAY RETAIN A COPY FOR MEDICAL FILE.

A fax or photo copy of the applicant‘s completed form will not be accepted.

WHERE TO SUBMIT THE COMPLETED ORIGINAL APPLICATION

First Time and Replacement of Temporary (red) and Long term (blue) Placards; Renewal of Temporary (red) Placards, and Special License Plates Applications.
Applicant must submit this form to a county issuing site. If the Physician/APRN certifies that the applicant is unable to appear in person because of a medical condition (see section 15 on Side 2), the applicant‘s authorized representative must present the applicant’s original I.D. along with the completed application form. A fax or photocopy of the applicant‘s completed form will **NOT** be accepted.

County Issuing Sites
The City and County of Honolulu – Satellite City Halls
Maui County – Division of Motor Vehicles & Licensing
Hawaii County – Office of Aging
Kauai County – Department of Finance

Renewal of a Long Term (blue) Placard.
Completed original form must be mailed to: DCAB, P.O. Box 3377, Honolulu, HI 96801

First Time, Replacement, or Renewal of a Disabled Paid Parking Exemption Permit/DPPEP (green) Placard.
Completed original form, a copy of the applicant‘s valid driver’s license, and payment if the application is for a replacement DPPEP placard, must be mailed to: DCAB, P.O. Box 3377, Honolulu, HI 96801.

STATE OF HAWAII DISABILITY AND COMMUNICATION ACCESS BOARD

DISABILITY PARKING PERMIT APPLICATION

FOR OFFICIAL USE ONLY
First Placard #_____
Second Placard #_____
Expiration Date _____
License Plates #_____
FEES COLLECTED, IF APPLICABLE
Amount Collected $ _____
_____ Clerk's Initial _____ Date

Applicant must present valid I.D. or if mailing the form, attach a legible copy. In lieu of an I.D. a notarized affidavit may be attached from: a Hawaii State or County social service agency, the administrator of a Hawaii State or private nursing home, the spouse, an adult relative, a friend, an assistant, the certifying physician, physician assistant (AMD), or advanced practice registered nurse (APRN).

SUBMIT THIS **ORIGNAL FORM** AS FOLLOWS:

Temporary (red) first time or renewing upon expiration – submit form, $12, and valid I.D. to a County issuing site.
Long term (blue) first time - submit form and valid I.D. to a County issuing site.
Long term (blue) renewal upon expiration – mail form to: DCAB, P.O. Box 3377, Honolulu, HI 96801.
Temporary (red) or long term (blue) replacement due to loss, confiscation, or mutilation – submit form, valid I.D., and a $12 payment to a County issuing site. No payment required for mutilated placards that are submitted to a County issuing site.
Disabled paid parking exemption permit (DPPEP) (green) for first time, renewing, or replacing – mail form and a copy of your valid driver's license to: DCAB, P.O. Box 3377, Honolulu, HI 96801. For DPPEP application, #16 and #17 must be completed by physician/APRN.
Physician, AMD, and APRN signatures are valid for 60 days, except for long term renewals which are valid for 180 days.

APPLICANT INFORMATION (Please print or type clearly)

1. FIRST NAME	MIDDLE INITIAL	LAST NAME	SUFFIX

2. PHONE NUMBER	3. EMAIL ADDRESS (optional)

4. DATE OF BIRTH (mm/dd/yyyy)	5. HEIGHT (Feet, Inches)	6. WEIGHT (Pounds)	7. Gender ☐ Male ☐ Female ☐ X

8. MAILING ADDRESS	APT #

CITY	STATE	ZIP CODE

9. INDICATE THE COUNTY WHERE YOU LIVE
☐ City and County of Honolulu ☐ County of Hawaii ☐ County of Kauai ☐ County of Maui

10. PARKING PLACARD REQUEST
☐ First time application (red, blue, or green placard; or special license plates) ☐ Second temporary (red) placard
☐ Renewing placard or plate # _____ Second placard (if any) # _____
☐ Replacing a confiscated, lost, stolen, or mutilated temporary (red) or long term (blue) placard #_____
☐ Replacing a confisatced, lost, or stolen DPPEP (green) placard # E _____
* First replacement $30 / Second replacement $60 / Third replacement $90 / Subsequent replacements $120
Mail application with check or money order made payable to: Department of Health
☐ Replacing a mutliated DPPEP (green) placard # E_____
(include placard with form)

11. **(OPTIONAL) COMPLETE ONLY IF REQUESTING SPECIAL LICENSE PLATES (DP)**

☐ I currently have special license plates. DP #_____ ☐ Plates were confiscated, lost, or stolen.

☐ 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. #	Vehicle Registration Expiration Date

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 authorize DCAB to contact the email listed in #3 if provided. I also authorize my physician, physician assistant, or advanced practice registered nurse to release medical information necessary to process this application.

_____ _____
APPLICANT ORIGINAL SIGNATURE (or Authorized Representative) Date (mm/dd/yyyy)

CERTIFICATION BY LICENSED PRACTICING PHYSICIAN/AMD/APRN

All sections on this page must be completed by a licensed practicing physician or physician assistant (AMD) as defined under Hawaii Revised Statutes (HRS) §§453, 455, or 463E, or an advanced practice registered nurse (APRN) as defined under HRS §457. The physician, AMD, or 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 items A and B (as defined under HRS §291-51). Individuals who belong to any of the following classes **do not** qualify for a permit based 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. CERTIFICATION OF CONDITION (**Must check at least one box in (A) and at least one box in (B)):**

I certify that applicant name: _____ has a disability that limits or impairs the ability to walk and has been diagnosed with one of the following conditions:

→ **(A)** (i) ☐ Arthritic ☐ Neurological ☐ Orthopedic ☐ Oncologic ☐ Renal ☐ Vascular

(ii) LUNG DISEASE:

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

☐ P3O2 < 60 mm/hg – Arterial oxygen tension is less than sixty mm/hg on room air at rest.

(iii) CARDIAC 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.

AND

→ **(B)** Because of the condition identified in #13A, the applicant (Must check at least one):

☐ Cannot walk 200 feet (under his/her own power) without stopping to rest

☐ Cannot walk (under his/her own physical power) without the use of, or assistance from, the following:

☐ Artificial Lower Limb(s) ☐ Brace(s) ☐ Crutches ☐ Walkers ☐ Cane(s) (excluding white cane)

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

☐ Uses portable oxygen

14. DURATION OF DISABILITY:

Mark one box only. If the disability lasts longer than anticipated, subsequent certification can be made.

Temporary (red) ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Long Term (blue) ☐ 6 years (disability is expected to last a minimum of 6 years)

15. APPLICANT EXEMPTION FROM APPLYING IN PERSON (Mark only if applicable)

I certify that this applicant is exempt from applying in person due to a medical reason. _____

Physician/AMD/APRN Signature

16. **REQUIRED.** PHYSICIAN/APRN/AMD CERTIFICATION. I understand that per HRS §291-51.4, a physician/AMD/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.

FIRST NAME	LAST NAME	MI	PHONE NUMBER

MAILING ADDRESS	CITY	HI	ZIP CODE

MEDICAL LICENSE NO. (Hawaii or U.S. Armed Services Stationed in HI)	CIRCLE ONE: MD /MDR / ND / DOS / DOSR / PO / APRN / AMD / NPI
PHYSICIAN/AMD/APRN SIGNATURE	DATE (mm/dd/yyyy)

17. **OPTIONAL.** CERTIFICATION FOR DISABLED PAID PARKING EXEMPTION PERMIT: **COMPLETE ONLY IF APPLICANT QUALIFIES.** To qualify, applicant **MUST** have (1) a **VALID DRIVER'S LICENSE**, (2) a mobility disability described in #13(A) and #13(B) above, and (3) one of the conditions below. I physician/AMD/APRN certify that: (check at least one)

☐ The applicant cannot reach above the applicant's head to a height of 42 inches from the ground due to a lack of finger, hand, or upper extremity strength or mobility;

☐ The applicant cannot approach a parking meter due to the use of a wheelchair or other mobility device; or

☐ The applicant cannot manage, manipulate, and insert coins, bills, or cards in a parking meter or pay station due to a lack of fine motor control in both hands.

FIRST NAME	LAST NAME	MI	PHONE NUMBER

MAILING ADDRESS	CITY	HI	ZIP CODE

MEDICAL LICENSE NO. (Hawaii or U.S. Armed Services Stationed in HI)	CIRCLE ONE: MD / MDR / ND / DOS / DOSR / PO / APRN / AMD / NPI
PHYSICIAN/AMD/APRN SIGNATURE	DATE (mm/dd/yyyy)