

**APPLICATION FOR PUBLIC SWIMMING POOL PERMIT**  
 (Please type or print in blue or black ink)

<b>(OFFICIAL USE ONLY)</b> <b>PERMIT NO.</b>
<b>EXPIRATION DATE</b>

**NAME OF FACILITY/COMPLEX**  
 (Hotel, Condominium, Apartment, Townhouse, Recreation Center, School, Amusement Park, Etc.)

**POOLS SHARING THE SAME RECIRCULATION SYSTEM MAY BE LISTED UNDER ONE PERMIT. LIST POOLS**

1) \_\_\_\_\_ 4) \_\_\_\_\_  
 2) \_\_\_\_\_ 5) \_\_\_\_\_  
 3) \_\_\_\_\_ 6) \_\_\_\_\_

<b>POOL LOCATION ADDRESS</b>		<b>TAX MAP KEY</b>			
STREET: _____		ZONE	SECTION	PLAT	PARCEL
CITY: _____ ZIP CODE: _____					
<b>OWNER NAME (Corp., LLC, Partnership, AOA, Sole Owner, Etc.)</b>		<b>CONTACT PHONE #</b>		<b>OTHER PHONE #</b>	

**MAILING ADDRESS (If different from pool location address)**

ATTN OR C/O: \_\_\_\_\_

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**E-MAIL ADDRESS: (Optional)**

**I UNDERSTAND THAT THE ISSUANCE OF THE PUBLIC SWIMMING POOL PERMIT IS CONTINGENT UPON COMPLIANCE WITH THE REQUIREMENTS OF HAWAII ADMINISTRATIVE RULES, TITLE 11, CHAPTER 10, "PUBLIC SWIMMING POOLS," AND AFTER ISSUANCE, THE PERMIT SHALL BE NON-TRANSFERABLE AND VALID FOR FIVE YEARS UNLESS SUSPENDED OR REVOKED FOR FAILURE TO COMPLY WITH THE PROVISIONS OF THIS CHAPTER.**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF OWNER/AGENT**

\_\_\_\_\_  
**PHONE # OF OWNER/AGENT**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**TITLE**

**FEE AMOUNT: \$50.00 (NON-REFUNDABLE)**

**MAKE CHECK PAYABLE TO: STATE OF HAWAII (BANK ACCOUNT NAME AND ADDRESS MUST BE ON CHECK)**

**SUBMIT COMPLETED APPLICATION AND FEE TO:** ENVIRONMENTAL HEALTH FACILITY  
 1582 KAMEHAMEHA AVENUE  
 HILO, HI 96720

THERE WILL BE A SERVICE FEE OF \$25.00 FOR ANY CHECK DISHONORED BY THE BANK.

**SECTION BELOW FOR OFFICIAL DEPARTMENT OF HEALTH USE ONLY**

Sandistrict	Last Regular Inspection Date	Inactive Date: _____	By: _____	SU: _____
		Reason: _____		
POOL TYPE: (CIRCLE ONE)		Fresh Water	Salt Water	
APPLICATION TYPE: (CIRCLE ONE)		New	Renewal	Facility/Complex Name Change
Fee Paid	Date Paid	Method of Payment	Receipt No.	Received By
APPROVED BY:				
DATE		SIGNATURE OF AGENT/DEPT. OF HEALTH		R.S. LIC. NO.
DATE PERMIT MAILED: _____		CHECKED: SU _____	DI _____	