PERSON	WITH A	ATION	FOR OFFICIAL USE ONLY			
TE OF HAL	FIRS	T TIME, TEMPORARY &		ARDS 1 ST	Placard #	
959 [DISABIL	STATE OF H ITY AND COMMUNICAT		2 nd	Placard #	
	This forn	າ must be taken to a Coເ	Inty issuing site. Applica	ant must Exp	piration Date	
		oof of identity. All forms of identity. All forms of identity of ID include:			ense Plates #	
		parent or guardian of a minor		l affidavit	ES COLLECTED,	
		county social service ager d nursing home, the spous		a Hawali	ount Collected \$ _	
assistant, the v	erifying p	hysician or verifying advanc	ed practice registered nur	se. X_	erk's Initials	
		on behalf of the applican nust be presented to the			erk's Initials	Date
		ng must also present his/			ncy.	
1. APPLICANT	S NAME		Last			
	-		First			MI
2. PHONE NUM	BER		2a. EMAIL			
		(xxx) xxx-xxxx		0	ptional	
3. BIRTH DATE		4. HEIGHT	5. WEIGHT	6. GEND	DER 🔲 Male	E Female
7. RESERVED.	mm/dd	l/year Feet, Ir	nches Pour	nds		
8. MAILING AD	DRESS					
0			Street		Apt #	
		City	State		Zip Code	
· _ ·		Y WHERE YOU LIVE onolulu County of I	Hawaii 🔲 County of I			
Mark applicat	ole box and e temporation emporary of my Ha	EQUEST (Switching from a tend enter serial number of platary or long term placard placard waii temporary placard(s) y Hawaii placard(s)		am requesting a	3:	
I am inte	rested in Jesting sp	REQUESTING SPECIAL LICI receiving information on hove becial license plates. I am th D the vehicle will be used p	w to apply for special licen e registered owner of the			
Year of Vehicle _		Make	Me	odel		
Vehicle Lic. #		Vehicle Re	gistration Expiration Date			
					mm/dd/year	
I declare, under th and accurate, and	e penaltie I that I ha rith. I also	UTHORIZATION TO RELEA s of the penal law, that the st ve not knowingly and willingl authorize my physician or ac	atements contained herein y made a false statement of	are, to the best or given information	tion which I know	v to be false in
x A	PPLICAN	'S SIGNATURE (or Authorized	d Representative)		Date	
	-	· · · · · · · · · · · · · · · · · · ·	• • •			

CERTIFICATION BY LICENSED PRACTICING PHYSICIAN/APRN

This page must be completed by a licensed practicing physician (as defined under Hawaii Revised Statutes (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 conditions 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 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. I ce	rtify that _					has a disa	bility that limi	ts or impairs t	he ability to	walk and
				nťs Name		_				
(a)		OT WALK Arthritic	(under his/hei	r own power) 2 jical		stopping to r	est due to the Renal	e following co Vascu		
(b)				RESPIRATOR biratory) expirat			when measu	ired by spirom	netry, is less	;
	🗖 F	P ₃ O₂ < 60		erial oxygen te	nsion is less th	an sixty mm/ł	ng on room a	ir at rest.		
(c)	ЦĞ	Class III -	Patients with rest. Less that Patients with Symptoms of	HEART CONE cardiac diseas an ordinary phy cardiac diseas cardiac insuffi ity is undertake	e resulting in r sical activity c e resulting in i ciency or of th	narked limitati auses fatigue, nability to carr e anginal synd	on of physica , palpitation, o ry on any phy	al activity. The dyspnea, or a vsical activity v	ey are comfo nginal pain. without disco	omfort.
(d)	CANNO	T WALK	(under his/he	r own power) w	ithout the use	of, or assistar	nce from, the	following:		
		Artificial Lo	ower Limb(s)	Brace(s)	Crutches	Walker	Cane	e(s) (excludino	g white cane	es)
	ΠA	Another P	erson	Wheelcha	ir 🔲 Other As	sistive Device	e (specify):			
(e)		JSES PO	RTABLE OXY	GEN.						
	PLICANT	IS UNA	BLE TO APPL	Ability is expendent Y IN PERSON sically unable t	(Mark only if	applicable)			n's/APRN's S	Signature
applica a separ	nt is qual rate offen	ified for p	urposes of this 3 conducts ran	N. I understanc s form shall be dom checks to	guilty of a pett	y misdemean	or and each f		-	
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b. MAII		DRESS							HI 96	
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с. РНО	NE NUM	BER (808	3)							
d. PHY	SICIAN'S	S/APRN'S	SIGNATURE	x						
MED	DICAL LIC	C . NO. M.	D. / N.D. / D.C (circle or	0. / D.P.M. / AP ne)	RN	# Hawaii or l	U.S. Armed Se	ervices Station	ned in Hawaii	i
e. DAT	E Mor	/ hth	/ Day	Year						

FOR PROCESSING SUBMIT COMPLETED FORM TO APPROPRIATE COUNTY ISSUING AGENCY. For more information or the locations of county issuing sites visit <u>http://health.hawaii.gov/dcab/</u> or call (808) 586-8121.

PERSON WITH A DISABILITY PARKING PERMIT APPLICATION FORM INSTRUCTION SHEET

Use Form PA-1 to apply for

First Time, Temporary, and Replacement Placards; and Special License Plates

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. PARKING PLACARD REQUEST. Mark the box next to the type of placard you are requesting.
 - A **First Time** placard. Mark this box if this is the first time that you are applying for a Long-term (blue in color) or Temporary (red in color) placard. A Temporary placard will be valid for no more than 6 months. There is a \$12 fee for a Temporary placard.
 - A Second Temporary placard. Mark this box if you would like a Second Temporary (red in color) placard. A second Temporary placard is an additional placard that has the same expiration date as its companion placard. If you already have a Temporary placard, print its serial number in the space provided. Check your ID card for the Temporary placard number. There is a \$12 fee for a Second Temporary placard.
 - A Renewal of a temporary placard(s). Mark this box if you want to renew your Temporary (red in color) placard(s). You may apply up to 60 days before it expires. Print the serial number of your expiring or expired Temporary placard(s) in the space provided. Check your ID card for your placard number(s). If you currently have two Temporary placards and want two renewal Temporary placards, make sure to enter the serial number of each expiring or expired placard in the space provided. YOU MUST ALSO HAVE YOUR DISABILITY RECERTIFIED BY A LICENSED PRACTICING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE (APRN). There is a \$12 fee for each Temporary placard issued.
 - A **Replacement** of a (**Lost, Stolen, Mutilated or Confiscated**) placard(s). Mark this box if your placard was lost, stolen, mutilated or confiscated. Print the serial number(s) of your placard(s) in the space provided. Check your ID card for the placard number(s). There is a \$12 fee for the replacement of a lost, stolen or confiscated placard. There is no fee for the replacement of a mutilated placard, but you must bring in its remaining parts, otherwise, it will be treated as a replacement of a lost placard and a \$12 fee will be charged.
- **11. 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 placard.
- **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 <u>do not</u> qualify: blindness; deafness; upper limb amputation; mental illness; old age; pregnancy; infancy; behavioral, learning, intellectual or developmental disabilities.
- 14. 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. 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.
- 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-1 – First Time, Temporary, and Replacement Placards; and Special License Plates Applications.

Applicant must submit the form in person at a county issuing site unless his or her Physician/APRN has certified the applicant is unable to appear in person because of a medical condition (see item#15). A person appearing on behalf of an applicant must present the applicant's ID or a legilble copy along with the completed application form.