CERTIFICATION BY LICENSED PRACTICING PHYSICIAN/APRN

All sections on 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 (APRN) (as defined under HRS §457). The physician 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 behaviorial, 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 physicial 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 without stopping to rest

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

☐ Artificial Lower Limb(s) ☐ Brace(s) ☐ Crutches ☐ Walker ☐ 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 ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Long Term ☐ 6 years (only check if disability is expected to last a minimum of 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/APRN Signature

16. **REQUIRED.** 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.

FIRST NAME	LAST NAME	MI	PHONE NUMBER

MAILING ADDRESS	CITY	HI	ZIP CODE

MEDICAL LIC. NO. (Hawaii or U.S. Armed Services Stationed in Hawaii)	CIRCLE ONE: MD / MDR / ND / DOS / DOSR / PO / APRN

PHYSICIAN/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/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.

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MEDICAL LIC. NO. (Hawaii or U.S. Armed Services Stationed in Hawaii)	CIRCLE ONE: MD / MDR / ND / DOS / DOSR / PO / APRN

PHYSICIAN/APRN SIGNATURE	DATE (mm/dd/yyyy)

STATE OF HAWAII • DISABILITY AND COMMUNICATION ACCESS BOARD

DISABILITY PARKING PERMIT APPLICATION

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 or advanced practice registered nurse (APRN). If certifying physician or APRN completes section 17, attach a copy of the applicant's valid unexpired driver's license.

SUBMITTING THIS FORM:

First time application for a temporary (red), long term (blue) placard, or special license plates; or renewing a temporary (red) placard – submit form and valid I.D. to a County issuing site.

Replacing a confiscated, lost, stolen, or mutilated temporary (red) or long term (blue) placard – 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.

Renewing an expiring long term (blue) placard – mail form to: DCAB, P.O. Box 3377, Honolulu, HI 96801.

Disabled paid parking exemption permit (DPPEP) (green) for first time, renewing, or replacing – mail form and a copy of 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.

FOR OFFICIAL USE ONLY

First Placard #_____

Second Placard #_____

Expiration Date_____

License Plates #_____

FEES COLLECTED, IF APPLICABLE

Amount Collected $_____

_____ _____

Clerk's Initials Date

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
8. MAILING ADDRESS			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. PARKING PLACARD REQUEST

☐ First time application (placards and special license plates) ☐ Second placard (only available for temporary (red) placard)

☐ Renewing placard #_____ Second placard (if any) #_____

☐ Replacing a confiscated, lost, stolen, or mutilated temporary (red) or long term (blue) parking placard #_____

☐ Replacing a confiscated, 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 mutilated DPPEP (green) placard # E_____
(include placard with form)

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

☐ I currently have special license plates. DP #_____

☐ 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 address listed in #3 if provided. I also authorize my physician or advanced practice registered nurse to release medical information necessary to process this application.

_____ _____

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