

CERTIFICATION BY LICENSED PRACTICING PHYSICIAN/APRN

This page must be completed by a licensed practicing physician (as defined under HRS §§453, 455, 460, and 463E), or an advanced practice registered nurse (as defined under HRS §457.8.6).

CERTIFICATION OF CONDITION The physician or an advanced practice registered nurse must certify that the applicant has one or more of the specific disabilities listed below (as defined under HRS §291-51). A list of conditions that do not qualify an applicant can be found on the web: <http://health.hawaii.gov/dcab>.

I certify that _____ meets at least one of the criteria below.
APPLICANT'S NAME

13. MARK APPROPRIATE BOX(ES). ONLY ONE CATEGORY IS REQUIRED.

- (a) The applicant is **UNABLE TO WALK** 200 feet without stopping to rest due to the following condition:
 Arthritic Neurologic 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.
 P₃O₂ < 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 is **UNABLE TO WALK** 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

- Temporary Disability for a duration of:
(Mark one box only. If the disability lasts longer than anticipated, subsequent certification can be made.)
 1 month 2 months 3 months 4 months 5 months 6 months
OR
 Long-term Disability

15. NOT ABLE TO APPLY IN PERSON (Mark only if applicable)

- The applicant is physically unable to apply in person due to a medical condition. × _____
PHYSICIAN'S/APRN'S SIGNATURE

16. PHYSICIAN or ADVANCED PRACTICE REGISTERED NURSE READ CAREFULLY I understand that per HRS §291 Part III, as a physician/advanced practice registered nurse (APRN), fraudulently verify that to obtain a parking permit, I shall be guilty of a petty misdemeanor, and each fraudulent verification shall constitute a separate offense. For program integrity, DCAB conducts random checks to verify the authenticity of certifications.

- a. **PHYSICIAN'S/APRN'S NAME** _____
(PRINT OR TYPE) LAST FIRST M.I.
- b. **MAILING ADDRESS** _____ HAWAII _____ 96 _____
(PRINT OR TYPE) STREET / P.O. BOX CITY ZIP CODE
- c. **PHONE NO.** (808) _____
- d. **PHYSICIAN'S/APRN'S SIGNATURE** × _____ **M.D. / N.D. / D.O. / D.P.M. / APRN**
(CIRCLE ONE)
- MEDICAL LIC. NO.** _____
(HAWAII / U.S. ARMED SERVICES STATIONED IN HAWAII)
- e. **DATE** _____ / _____ / _____
MONTH DAY YEAR

FOR PROCESSING, APPLICANT MUST SUBMIT THIS FORM TO THE APPROPRIATE ISSUING AGENCY.
First-time placards (blue in color) and **temporary placards** (red in color) are processed in person at a Satellite City Hall or County issuing site.
Replacement placards (lost, stolen, or mutilated) are processed in person at a Satellite City Hall or County issuing site for a fee.
Long-term placard renewals (blue in color) are processed by mail: DCAB, 919 Ala Moana Blvd., Rm. 101, Honolulu HI 96814
Application form can be found on the DCAB website: <http://health.hawaii.gov/dcab>.