



STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL

**APPLICATION FOR STATE OF HAWAII FIREARM CERTIFICATION
FOR QUALIFIED RETIRED LAW ENFORCEMENT OFFICERS
PURSUANT TO 18 UNITED STATES CODE § 926C**

Name _____
Last First Middle

Date of Birth _____ Place of Birth _____

Social Security No. _____ U.S. Citizen Yes No

U.S. Passport/Naturalization No. _____

Home Address _____
Street City State Zip Code

Email Address _____

Home Phone _____ Cell Phone _____

Employer _____ Bus. Phone _____

Public Law Enforcement (PLE) Agency from which you separated _____

PLE Agency Address _____
Street City State Zip Code

Occupation _____ Rank/Pay Grade at Separation _____

Start Date _____ Separation Date _____

Other Dates _____

Department Chief or Agency Head _____ Phone No. _____

The firearm I intend to carry concealed pursuant to 18 U.S.C. § 926C is _____
(Attach a copy of current registration)

Make & Model _____ Caliber _____ Serial Number _____

Type _____ State of Hawaii Firearm Registration No. _____

Place your hand-written initials on the line prior to each statement below to indicate that you have read, understand and agree with the statement.

_____ I understand that I am prohibited from carrying a concealed firearm if I am under the influence of alcohol or another intoxicating or hallucinatory drug or substance. See 18 U.S.C. § 926C(c)(6) and HFCP.

_____ I certify that the answers given above are true and correct.

_____ I further declare that I meet and understand all requirements of 18 U.S.C. §926C and H.R.S. chapter 134 to carry a concealed firearm in the State of Hawaii as a qualified retired law enforcement officer.

_____ I have read and understand the provisions of 18 U.S.C. § 926C and H.R.S. chapter 134.

_____ I understand that 18 U.S.C. § 926C and the State of Hawaii Firearms Certification card:

_____ does not make me an employee or agent of the State of Hawaii or the County of Hawaii, City and County of Honolulu, County of Kauai or County of Maui.

_____ does not make me a sworn law enforcement officer in the State of Hawaii or any other jurisdiction in the United States of America.

_____ I understand that I am subject to all laws and regulations in the State of Hawaii including but not limited to the firearms laws in chapter 134, H.R.S.

_____ I agree that the State of Hawaii and its counties assume no liability or responsibility for any actions I take while carrying a concealed firearm pursuant to 18 U.S.C. § 926C.

_____ I accept full responsibility and liability if an incident should happen to others or myself while I am carrying the concealed firearm listed above.

DO NOT sign below until instructed to do so by the agency personnel accepting your application form.

By signing below, I declare under penalty of law that the foregoing is true and correct.

_____ Last First Middle

_____ Applicant's Signature

_____ Date

_____ Print Witness' Name

_____ Witness' Signature

_____ Date

CONSENT TO RELEASE CONFIDENTIAL INFORMATION AND
WAIVER AUTHORIZING ACCESS TO CONFIDENTIAL INFORMATION AND RECORDS

I, _____, do freely, voluntarily and without coercion, and in compliance with 18 United States Code § 926C and Chapter 134, Hawaii Revised Statutes, consent to and authorize the Chief of Police for the County of Hawaii, City and County of Honolulu, County of Kauai, and County of Maui, the Attorney General of the State of Hawaii, or any other law enforcement agency from which the applicant retired from, access to any and all information and records which have a bearing upon my qualification as a “qualified retired law enforcement officer” for purposes of carrying a concealed weapon in the State of Hawaii pursuant to 18 U.S.C § 926C. I understand that my social security number will be provided to the law enforcement agency in order to verify my identity. Further, I understand that if the law enforcement agency does not respond to the questionnaire, I will not qualify as a “qualified retired law enforcement officer” pursuant to 18 U.S.C. § 926C and will NOT be issued a State of Hawaii Firearm Certification to carry a concealed weapon.

Last

First

Middle

Applicant's Signature

Date

Subscribed and sworn to before me
This _____ day of _____, 20_____.

Doc. Date _____ # of Pages _____
_____, _____ Circuit

Doc Description _____

Notary Public, State of Hawaii

Printed Name: _____

My Commission Expires: _____

Notary Signature Date

NOTARY CERTIFICATION

Authorization for Use or Disclosure of Protected Health Information (PHI)

Organization Disclosing PHI Name: State of Hawaii Adult Mental Health Division (AMHD) PO Box 3378 Honolulu, HI 96801-3378	Name of Individual/Organization (other than AMHD) Disclosing PHI Name: _____ _____ _____ _____
Organization That Will Receive the Individual's PHI Department of the Attorney General Criminal Justice Division 425 Queen Street Honolulu, HI 96813	
Client/Patient Whose PHI is Being Requested	
First Name: _____	Last name: _____
Address: _____ _____ _____	Birth date: _____ Social Security Number: _____
I authorize that the Following Protected Health Information be Used/Disclosed: (PLEASE INITIAL)	
_____ Mental Health _____ Substance Abuse Treatment and/or Counseling	
The Protected Health Information is Being Used or Disclosed for the Following Purposes <i>(At the request of the Individual is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.)</i> :	
To determine my qualification to own, possess, or control any firearm or ammunition.	
Authorization Duration (This authorization will be in force and effect until the event specified below. At that time, this authorization to use or disclose this protected health information expires).	
Expiration of Authorization Event That Relates to the Purpose of the Use or Disclosure: My disqualification from owning, possessing, or controlling any firearm or ammunition.	
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above stated county police department. I understand that a revocation is not effective to the extent that the county police department has relied on the use or disclosure of the protected health information.	
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be redisclosed without my authorization.	
Signature: _____	Date: _____
Print Name: _____	_____

TO BE COMPLETED BY EXAMINING PHYSICIAN:

PHYSICIAN: The items highlighted/bolded below indicate the physical requirements of the certification for which this individual is being considered. Indicate the individual's physical capacities for this certification by placing an "X" in the appropriate column opposite the number(s) highlighted. If the individual has any other physical limitation relating to physical requirements not highlighted or not covered by this form, indicate under "Remarks" on the next page. Whenever PARTIAL capacity is indicated, explain under "Remarks," giving specific quantities.

9. PHYSICAL REQUIREMENTS AND ENVIRONMENTAL FACTORS

	CAPACITY				CAPACITY		
	Full	Partial	None		Full	Partial	None
1. Outside				35. Straight pulling (hours)			
2. Outside and inside				36. Pulling - hand-over hand (hours)			
3. Excessive heat				37. Pushing (hours)			
4. Excessive cold				38. Reaching above shoulder			
5. Excessive humidity				39. Use of fingers			
6. Excessive dampness or chilling				40. Use of both hands			
7. Day atmospheric conditions				41. Walking (hours)			
8. Excessive noise, intermittent				42. Standing (hours)			
9. Constant noise				43. Crawling (hours)			
10. Dust				44. Kneeling (hours)			
11. Silica, asbestos, etc.				45. Repeated bending (hours)			
12. Fumes, smoke, or gases				46. Climbing - use of legs only (hours)			
13. Solvents (<i>degreasing agents</i>)				47. Climbing - use of legs & arms (hours)			
14. Greases and oils				48. Use of both legs			
15. Radiant energy				49. Operation of crane, truck, tug, tractor, or motor vehicle			
16. Electrical energy				50. Ability for rapid mental and muscular coordination simultaneously			
17. Slippery or uneven walking surfaces				51. Ability to use and desirability of using firearms			
18. Works around machinery with moving parts				52. Near vision correctable at 13 to 16 inches			
19. Moving objects or vehicles				53. Far vision correctable to 20/20 to 20/40			
20. Working on ladders or scaffolding				54. Far vision correctable to 20/50 to 20/100			
21. Working below ground				55. Specific visual requirement (<i>specify</i>)			
22. Unusual fatigue factors (<i>Specify</i>)				56. Use of both eyes			
23. Working with hands in water				57. Depth perception			
24. Explosives				58. Ability to distinguish basic colors			
25. Vibration				59. Ability to distinguish shades of colors			
26. Working closely with others				60. Hearing (<i>Aid permitted</i>)			
27. Works alone				61. Hearing without aid			
28. Protracted or irregular hours of work				62. Specific hearing requirements (<i>specify</i>)			
29. Heavy lifting - 45 pounds and over				63.			
30. Moderate lifting - 15 - 44 pounds				64.			
31. Light lifting - under 15 pounds				65.			
32. Heavy carrying - 45 pounds and over				66.			
33. Moderate carrying - 15 - 44 pounds				67.			
34. Light carrying - under 15 pounds				68.			

IMPAIRMENT CODES

00	NO REPORTABLE IMPAIRMENT
10	AMPUTATION - ONE EXTREMITY
11	AMPUTATION - TWO OR MORE EXTREMITIES
20	DEFORMITY OR IMPAIRED FUNCTION - UPPER EXTREMITY
21	DEFORMITY OR IMPAIRED FUNCTION - LOWER EXTREMITY OR BACK
30	VISION - BEST CORRECTED VISION OF POORER EYE NOT MORE THAN 20/200
31	VISION - BEST CORRECTED VISION OF BETTER EYE NOT MORE THAN 20/200
40	HEARING - SOME IN ONE EAR, NONE IN OTHER
41	HEARING - IN BOTH EARS AND MORE THAN 12/20 IN BETTER EAR WITHOUT AID
42	HEARING - 0/20 IN EACH EAR, INCLUDING SPEECH MALFUNCTION
50	TUBERCULOSIS - INACTIVE PULMONARY
51	ORGANIC HEART DISEASE (<i>Compensated</i>) - VALVULAR, ARRHYTHMIA, ARTERIOSCLEROSIS, HEALED CORONARY LESIONS
52	DIABETES - CONTROLLED
53	EPILEPSY - ADEQUATELY CONTROLLED
54	HISTORY OF EMOTIONAL OR BEHAVIORAL PROBLEMS REQUIRING SPECIAL PLACEMENT EFFORT

IMPAIRMENT CODE INSTRUCTIONS

If the person examined has or had any impairment(s) listed above, enter the code of the ONE impairment which is MOST limiting in item 12.

If none of the impairments apply, enter the code "00."

10. THIS PERSON SHOULD USE: PROPERLY FITTED EYEGASSES/CONTACT LENSES PROPERLY FITTED HEARING AID
OTHER PROSTHETIC AID (*specify*)

11. IN YOUR OPINION, IS THIS INDIVIDUAL, IN HIS/HER CURRENT PHYSICAL CONDITION, CAPABLE OF CARRYING AND
USING A CONCEALED FIREARM? ____ YES ____ NO
PROVIDE YOUR **REMARKS AND RECOMMENDATIONS** BELOW.

12. IMPAIRMENT CODE
(See attached codes.)

13. SIGNATURE OF PHYSICIAN OR EXAMINER	14. PHYSICIAN NAME (<i>Type or print</i>)	15. DATE
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15. LICENSE NUMBER & TYPE OF LICENSE	16. ADDRESS OF EXAMINING PHYSICIAN (<i>Type or print</i>)
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