

INACTIVATION APPLICATION

Legal Name: (First, Middle, Last OR Name of Corporation, Partnership, JV, LLC, LLP)			<input type="checkbox"/> BP Address	<input type="checkbox"/> Lic. Status/Address
Name on Record:			<input type="checkbox"/> History	<input type="checkbox"/> Employment
Residence or Business Address: (Include Apt. No., City, State & Zip Code)			<input type="checkbox"/> Class Status	<input type="checkbox"/> Insurance Status
Mailing Address: (ONLY if different from above)			Initials/Date	
Phone No.: (Days)	Social Security No. (Individuals only)	License No.:	FOR OFFICE USE ONLY	
TOTAL AMOUNT DUE. \$12.00				

Please be advised that a licensee on inactive status shall be considered as unlicensed and shall not engage in the practice of the licensed profession or vocation. Any person who violates this prohibition shall be subject to discipline under this chapter and the laws and rules of the licensing authority for that license. It shall be the responsibility of each licensee on inactive status to maintain knowledge of current licensing and renewal requirements.

GENERAL INSTRUCTIONS (Access this form via website at: cca.hawaii.gov/pvl)

1. Complete on-line fillable application **OR print LEGIBLY**. Check your license type on page 2. Answer ALL questions and sign application. Incomplete applications will not be accepted. Name changed? Attach a copy of your name change document.
2. For each inactive license request, the fee is \$12 (non-refundable).
Make check payable to: COMMERCE AND CONSUMER AFFAIRS. (check must be in U.S. dollars and be from a U.S. financial institution).

Note: A \$25 service charge shall be assessed for payments that are dishonored for any reason. Returned payments are considered NON-RECEIPT of your fee and application, and the inactive effective date is voided.
3. Please allow 10 business days for processing. You may visit the PVL License Search page at: pvl.ehawaii.gov/pvlsearch/ to confirm your inactive status.
4. Mail all items to:

PVL Licensing Branch Commerce & Consumer Affairs P.O. Box 3469 Honolulu, HI 96801	OR	Deliver to office location at: 335 Merchant Street, Room 301 Honolulu, HI 96813 Phone No.: (808) 586-3000
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Inac..... INA \$12
 Service Charge..... BCF..... \$25

Print Name of Applicant: _____

Date: _____

Check your license type:

- | | | |
|---|---|---|
| <input type="checkbox"/> ACTIVITY DESK | <input type="checkbox"/> GUARD | <input type="checkbox"/> PEST CONTROL FIELD REPRESENTATIVE |
| <input type="checkbox"/> ADVANCED PRACTICE REGISTERED NURSE | <input type="checkbox"/> GUARD AGENCY | <input type="checkbox"/> PEST CONTROL OPERATOR |
| <input type="checkbox"/> ATHLETIC TRAINER | <input type="checkbox"/> HEARING AID DEALER & FITTER | <input type="checkbox"/> PHARMACIST |
| <input type="checkbox"/> BARBER | <input type="checkbox"/> JOURNEYWORKER ELECTRICIAN | <input type="checkbox"/> PHARMACY |
| <input type="checkbox"/> BARBER SHOP | <input type="checkbox"/> JOURNEYWORKER INDUSTRIAL ELECTRICIAN | <input type="checkbox"/> PHARMACY - MISCELLANEOUS PERMIT |
| <input type="checkbox"/> BEAUTY INSTRUCTOR | <input type="checkbox"/> JOURNEYWORKER PLUMBER | <input type="checkbox"/> PHARMACY - WHOLESALE DISTRIBUTOR |
| <input type="checkbox"/> BEAUTY OPERATOR | <input type="checkbox"/> JOURNEYWORKER SPECIALTY ELECTRICIAN | <input type="checkbox"/> PHYSICIAN ASSISTANT |
| <input type="checkbox"/> BEAUTY SCHOOL | <input type="checkbox"/> LICENSED PRACTICAL NURSE | <input type="checkbox"/> PHYSICAL THERAPIST |
| <input type="checkbox"/> BEAUTY SHOP | <input type="checkbox"/> LICENSED BACHELOR SOCIAL WORKER | <input type="checkbox"/> PHYSICAL THERAPIST ASSISTANT |
| <input type="checkbox"/> BEHAVIOR ANALYST | <input type="checkbox"/> LICENSED SOCIAL WORKER | <input type="checkbox"/> PRIVATE DETECTIVE |
| <input type="checkbox"/> CERTIFIED GENERAL APPRAISER | <input type="checkbox"/> MAINTENANCE ELECTRICIAN | <input type="checkbox"/> PRIVATE DETECTIVE AGENCY |
| <input type="checkbox"/> CERTIFIED RESIDENTIAL APPRAISER | <input type="checkbox"/> MARRIAGE & FAMILY THERAPIST | <input type="checkbox"/> PSYCHOLOGIST |
| <input type="checkbox"/> CHIROPRACTOR | <input type="checkbox"/> MASSAGE THERAPIST | <input type="checkbox"/> REGISTERED NURSE |
| <input type="checkbox"/> CONTRACTOR | <input type="checkbox"/> MASSAGE ESTABLISHMENT | <input type="checkbox"/> RESPIRATORY THERAPIST |
| <input type="checkbox"/> DENTIST | <input type="checkbox"/> MASTER PLUMBER | <input type="checkbox"/> STATE LICENSED REAL ESTATE APPRAISER |
| <input type="checkbox"/> DENTAL HYGIENIST | <input type="checkbox"/> MENTAL HEALTH COUNSELOR | <input type="checkbox"/> SUPERVISING ELECTRICIAN |
| <input type="checkbox"/> DISPENSING OPTICIAN | <input type="checkbox"/> NATUROPATH | <input type="checkbox"/> SUPERVISING INDUSTRIAL ELECTRICIAN |
| <input type="checkbox"/> ELECTROLOGIST | <input type="checkbox"/> NURSING HOME ADMINISTRATOR | <input type="checkbox"/> SUPERVISING SPECIALTY ELECTRICIAN |
| <input type="checkbox"/> EMPLOYMENT AGENCY | <input type="checkbox"/> OCCUPATIONAL THERAPIST | <input type="checkbox"/> TRAVEL AGENCY |
| <input type="checkbox"/> EMPLOYMENT AGENCY PRINCIPAL | | <input type="checkbox"/> VETERINARIAN |

I hereby certify that the answers, statements, and representations made on this application and the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (Section 710-1017, and 436B-19 Hawaii Revised Statutes).

Signature of Applicant/Officer/Partner/Manager/Member

Date

Print Name of Applicant/Officer/Partner/Manager/Member

Title of Applicant/Officer/Partner/Manager/Member

(CONTINUED ON PAGE 3)

Print Name of Applicant: _____

Date: _____

Release of Information to Third Party:

To assist me in the licensing process, I authorize DCCA's staff to release any and all information regarding my application (including, but not limited to application status) to the following third party:

Name of Individual who is assisting you: _____

Name of Organization: _____

Address of Organization: _____

Signature of Applicant

Date