INACTIVATION APPLICATION (For Health Care Professionals)

Legal Name: (First, Middle, Last **OR** Name of Corporation, Partnership, JV, LLC, LLP)

Name on Record:

Residence or Business Address: (Include Apt. No., City, State & Zip Code)

Mailing Address: (ONLY if different from above)

PERSONAL E-Mail Address:

Phone No.: (Days)	Social Security No. (Individuals only)	License No.:

FOR OFFICE USE ONLY

- ☐ BP Address
- ☐ Lic. Status/Address
- ☐ History
- ☐ Employment
- ☐ Class Status
- ☐ Insurance Status

Initials/Date

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

(CONTINUED ON PAGE 2)

Inac . . . . . INA $12
Service Charge. . . . . BCF $25

Print Name of Applicant: _____ Date: _____

Check your license type:

- ☐ ADVANCED PRACTICE REGISTERED NURSE
- ☐ LICENSED PRACTICAL NURSE
- ☐ REGISTERED NURSE
- ☐ NATUROPATH
- ☐ PHYSICIAN ASSISTANT

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

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

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.