

## **REQUIREMENTS FOR ADMISSION TO THE DEPUTY PORT PILOT EXAMINATION & LICENSE**

APPLICANTS ARE SUBJECT TO REQUIREMENTS IN EFFECT AT THE TIME OF FILING.  
APPLICANTS MUST BE AT LEAST 18 YEARS OF AGE.

- APPLICATION** Complete the attached application form by typing or printing *legibly* in dark ink. **Attach** appropriate fee and supporting documents.
- FEES/EXAM** **Attach** the application fee of \$25 (non-refundable). Upon notification of approval to sit for the exam a notice will be sent requesting the exam fee of \$500. Make check payable to: **COMMERCE & CONSUMER AFFAIRS**. (check must be in U.S. dollars and be from a U.S. financial institution.)
- DOCUMENTS REQUIRED** **Attach** a copy of a current U.S. Coast Guard license as master of steam and motor vessels or any gross tonnage upon oceans issued by the U.S. Coast Guard.
- Attach** a copy of your Coast Guard endorsement as a first class pilot for all deep draft harbors where pilot services are provided in the state.
- EXPERIENCE** **Submit** a written statement signed by yourself showing evidence that you have the following experience:
- a. Four years of ocean or coastwise service as a licensed deck officer, including at least one year as chief officer, on vessels of one thousand or more gross tons; or
  - b. Two years of ocean or coastwise service as a licensed deck officer on vessels of one thousand gross tons or more, plus one year of pilot service, docking registered or enrolled vessels of at least 5,000 gross tons.
  - c. The requirement to have served at least one year as chief officer may be substituted on a month-to-month basis by experience as a master of tugs, engaged in docking and undocking vessels of 5,000 gross tons or more.
  - d. A minimum of fifty round trips in and out of Honolulu Harbor to and from the various piers as an observer. Twenty-five of these trips shall have been on vessels over 5,000 gross tons and at least ten shall have been during hours of darkness.
- MEDICAL EXAM** **Submit** proof of medical examination **within the previous 60 days** with a physician's report certifying the absence of any physical and mental impairment that would appear to be likely to interfere with your performance of the duties as a port pilot.
- LAWS & RULES** Copies of the Pilotage law, Chapter 462A, HRS, and Chapter 96, Hawaii Administrative Rules are available by submitting a written request to: Port Pilot Program, Commerce and Consumer Affairs, P.O. Box 3469, Honolulu, Hawaii 96801. Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Act should be read in conjunction with Chapters 462A and Chapter 96.
- REGISTRATION** After all requirements are fulfilled, license fees will be due. Notification of amounts will be sent to you at the appropriate time.

(CONTINUED ON PAGE 2)

**BIENNIAL  
REGISTRATION**

All licenses, regardless of issuance date, expire June 30 of each EVEN-NUMBERED year and are subject to renewal. Failure to do so would mean forfeiture of the license.

To ensure receipt of the renewal application, which is mailed about 45 days prior to the license expiration date, keep the Board's office informed of your current mailing address.

**APPLICANTS  
WITH  
SPECIAL NEEDS**

If you are requesting special testing arrangements due to a disability, call (808) 586-2711 immediately to obtain a Disability Certification form which must be completed by an approved professional, and submitted preferably prior to your exam application, but no later than the exam filing deadline. Determination of qualification for special testing arrangements will then be made and if so, the type of special testing arrangements to be provided.

No action will be taken to provide special testing arrangements until your exam application has been approved.

**REQUIREMENTS FOR PORT PILOT LICENSE**

Serve a minimum of 18 months as a deputy port pilot licensed by the State of Hawaii.

**APPLICATION**

Complete the attached application form by typing or printing *legibly* in dark ink. **Attach** appropriate fee and supporting documents.

**FEES**

**ATTACH** appropriate amount made payable to: **COMMERCE & CONSUMER AFFAIRS**. (check must be in U.S. dollars and be from a U.S. financial institution.)

If license will be issued between July 1, EVEN-NUMBERED years and June 30, ODD-NUMBERED years, pay ..... \$743  
(Application - \$25\*\*, License - \$380, Compliance Resolution Fund - \$148, 1/2 Renewal - \$190)

If license will be issued between July 1, ODD-NUMBERED years and June 30, EVEN-NUMBERED years, pay ..... \$479  
(Application - \$25\*\*, License - \$380, Compliance Resolution Fund - \$74)

**NOTE:** *One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a \$25.00 service fee will be charged for checks which are returned by the bank.*

*If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.*

\* Subject to renewal June 30, even-numbered year.  
\*\* Application fee is not refundable.

**DOCUMENTS  
REQUIRED**

**Attach** a copy of a current U.S. Coast Guard license as master of steam or motor vessels of a tonnage.

**Attach** a copy of endorsements as a first class pilot for all deep draft harbors in the state where pilot services are provided.

**Submit** a summary of all pilotage work performed **and** will evaluation forms.

**MEDICAL  
EXAM**

**Submit** proof of medical examination **within the previous 60 days** with a physician's report certifying the absence of any physical and mental impairment that would appear to be likely to interfere with your performance of the duties as a port pilot.

**BOARD'S  
ADDRESS**

Mail all required items to:

Port Pilot Program  
DCCA, PVL, Licensing Branch  
P.O. Box 3469  
Honolulu, HI 96801

Deliver to office location:

OR

335 Merchant St., Room 301  
Honolulu, HI 96813

**RELEASE OF  
INFORMATION**

If an agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete the portion on **Release of Information to Third Party**, sign and date it.

**ABANDONMENT  
OF APPLICATION**

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indication that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

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.

# APPLICATION FOR PORT PILOT/DEPUTY PORT PILOT LICENSE

**PORT PILOT PROGRAM**  
 Professional and Vocational Licensing Division  
 Department of Commerce and Consumer Affairs  
 State of Hawaii  
 335 Merchant St., Room 301  
 P.O. Box 3469  
 Honolulu, HI 96801

FOR OFFICE USE	Initials/Date:	
	<input type="checkbox"/> Approved	
	Effective Date:	License No.

Read the requirements (PP-00) before completing this application. The applicable license fee must accompany this application.

CHECK ONE:       Port Pilot                       Deputy Port Pilot

Legal Name (First, Middle):	(Last):
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Residence Address (include apt. no., city, state & zip code):	Mailing Address (ONLY if different from residence):
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Social Security No.:	Business Phone:	Residence Phone:
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Birthplace (City/State/Country):	Date of Birth:	Age:
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USCG Unlimited Masters License No.:	Date Issued:
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USCG First Class Pilot License No.:	Date Issued:
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See letter dated \_\_\_\_\_, which outlines fully my answer to the experience requirements listed on the "Requirements" sheet attached to this application.

**AFFIDAVIT OF APPLICANT:**

I hereby certify that the answers and statements in this application and in the letter attached are true, correct and complete and that there are no misrepresentations or material omissions with respect to any matter that may be relevant to the Department's consideration of this license application. I understand that breach of this certificate is grounds for rejection or subsequent revocation of license (*Section 710-1017, Sections 436B-19 and 462A-8, Hawaii Revised Statutes*).

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Applicant

(CONTINUED ON PAGE 2)

App..... 536..... \$25  
Exam - PP/DPP..... 532..... \$500

Lic - PP/DPP..... 533..... \$380/\$96  
CRF..... 537..... \$74/\$148  
1/2 Ren - PP/DPP... 530..... \$190/\$48  
Service Fee ..... BCF..... \$25

Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**Release of Information to Third Party:**

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

Print Name of Individual who is assisting you: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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.

## CERTIFICATE OF MEDICAL EXAMINATION FOR PORT PILOT AND DEPUTY PORT PILOT

### APPLICANT'S SECTION

Legal Name (First-Middle-Last):	<input type="radio"/> Female <input type="radio"/> Male
Residence Address (include apt. no., city, state and zip code):	Date of Birth:
	Social Security No.:

**JOB DESCRIPTION - Port Pilot and Deputy Port Pilot:**

Pilots vessels into and out of State harbors, directing movements of vessel being maneuvered. Boards and disembarks vessels off port, often in rough seas, climbing pilot ladders to heights in excess of 40 feet. (These are flexible "Jacobs" ladders hanging free over the side of the ship.) Piloting involves outside work and exposure to all weather conditions. Subject to protracted and irregular hours of work. Requirement for high mental alertness as well as physical fitness, including requirement for night vision.

HAVE YOU ANY PHYSICAL DEFECT OR DISABILITY WHATSOEVER? .....  YES  NO

If "YES", give details on a separate sheet of paper and attach to application.

\_\_\_\_\_ Signature of Applicant \_\_\_\_\_ Date

**Sign your name in INK as it appears on your application in the presence of the physician for purpose of identification.**

\_\_\_\_\_ Print Name of Applicant

### PHYSICIAN'S SECTION

All questions on this form must be answered. Please sign this certificate and mail results directly to the Port Pilot Program, Department of Commerce & Consumer Affairs, P.O. Box 3469, Honolulu, HI 96801.

HEIGHT: \_\_\_\_\_ FEET \_\_\_\_\_ INCHES      WEIGHT: \_\_\_\_\_ POUNDS

EYES:

	<u>20</u>	<u>20</u>	
(A) DISTANT VISION ( <i>Snellen</i> ):	WITHOUT GLASSES:	RIGHT _____	LEFT _____
	WITH GLASSES, IF WORN:	RIGHT _____	LEFT _____

(B) WHAT IS THE LONGEST AND SHORTEST DISTANCE AT WHICH THE FOLLOWING SPECIMEN OF JAEGER NO. 2 TYPE CAN BE READ BY THE APPLICANT? TEST EACH EYE SEPARATELY.

WITHOUT GLASSES:	WITH GLASSES, IF USED:
RIGHT _____ IN. TO _____ IN.	RIGHT _____ IN. TO _____ IN.
LEFT _____ IN. TO _____ IN.	LEFT _____ IN. TO _____ IN.

(CONTINUED ON PAGE 2)

Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

EYES: (cont'd)

(C) EVIDENCE OF DISEASE OR INJURY: RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

(D) COLOR VISION: IS COLOR VISION NORMAL WHEN ISHIIHARA OR OTHER COLOR PLACE TEST IS USED? .....  YES  NO

IF NOT, CAN APPLICANT PASS OTHER COMPARABLE TEST? .....  YES  NO

EARS:

(CONSIDER DENOMINATORS INDICATED HERE AS NORMAL. RECORD AS NUMERATORS THE GREATEST DISTANCE HEARD)

ORDINARY CONVERSATION:

EVIDENCE OF DISEASE OR INJURY:

RIGHT EAR \_\_\_\_\_ LEFT EAR \_\_\_\_\_  
20 Feet 20 Feet

RIGHT EAR \_\_\_\_\_ LEFT EAR \_\_\_\_\_

NOSE	PARA NASAL SINUSES	MOUTH AND THROAT	GASTRO-INTESTINAL
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HISTORY OF PEPTIC ULCER:  YES  NO IF "YES", IS ULCER:  ACTIVE  QUIESCENT  HEALED

HOW LONG? \_\_\_\_\_ DATE OF LAST X-RAY \_\_\_\_\_

SYMPTOMS PRESENT, IF ANY (*Severity, frequency, etc.*): \_\_\_\_\_

TREATMENT (*Use space under "Remarks", if needed*): \_\_\_\_\_

METABOLIC DISORDERS: (INDICATE ANY ABNORMALITY OF THE FOLLOWING GLANDS BY A CHECK IN THE APPROPRIATE BOX, AND EXPLAIN BELOW).  THYROID  PANCREAS  PITUITARY  OVARIAN

HEART AND BLOOD VESSELS:

(A) BLOOD PRESSURE: MM, HG SYSTOLIC \_\_\_\_\_ DIASTOLIC \_\_\_\_\_

(B) ORGANIC HEART DISEASE PRESENT?  YES  NO

(C) IF ORGANIC HEART DISEASE IS PRESENT, IS IT FULLY COMPENSATED?  YES  NO

(D) PULSE RATE:  
SITTING \_\_\_\_\_ IMMEDIATELY AFTER EXERCISE (UNLESS CONTRAINDICATED) \_\_\_\_\_

TWO MINUTES AFTER EXERCISE \_\_\_\_\_ CARDIAC RESERVE:  GOOD  FAIR OR  POOR

(CONTINUED ON PAGE 3)

Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

LUNGS:

RIGHT \_\_\_\_\_

LEFT \_\_\_\_\_

(A) HISTORY OF TUBERCULOSIS?  YES  NO

IF "YES", DESCRIBE: \_\_\_\_\_

(B) IS THERAPY BEING RECEIVED AT PRESENT?  YES  NO

IF "YES", GIVE FULL DETAILS BELOW: \_\_\_\_\_

(C) IS MEDICAL SUPERVISION NECESSARY?  YES  NO

PLEASE REPORT SPUTUM AND X-RAY TEST AND FINDINGS: \_\_\_\_\_

HERNIA:  YES  NO IF "YES", NAME VARIETY: INGUINAL, VENTRAL, FEMORAL, POST-OPERATIVE, ETC.: \_\_\_\_\_

IF PRESENT, IS IT SUPPORTED BY A WELL-FITTING TRUSS?  YES  NO

VARICOSE VEINS:  YES  NO IF "YES", STATE LOCATION AND DEGREE: \_\_\_\_\_

FEET:

IS FLAT FOOT PRESENT?  YES  NO

IF "YES", STATE DEGREE OF IMPAIRMENT OF FUNCTION:  NONE  SLIGHT  MODERATE  SEVERE

DEFORMITIES, ATROPHIES, AND OTHER ABNORMALITIES, DISEASE NOT INCLUDED ABOVE:

SCARS OF SERIOUS INJURY OR DISEASE:

NERVOUS SYSTEM: (INCLUDE SYMPTOMS AND FULL HISTORY OF ANY MENTAL, NERVOUS OR EMOTIONAL ABNORMALITY. USE ADDITIONAL SHEETS IF NECESSARY):

(A) HAS APPLICANT EVER BEEN HOSPITALIZED OR TREATED FOR A MENTAL ILLNESS?  YES  NO

(B) WHERE (NAME AND LOCATION OF HOSPITAL): \_\_\_\_\_

(C) DATE OR DATES OF HOSPITALIZATION: \_\_\_\_\_

(D) DESCRIBE ANY RESIDUALS OF PREVIOUS MENTAL OR NERVOUS ILLNESS: \_\_\_\_\_

(E) ANY HISTORY OF EPILEPSY OR FAINTING SPELLS?  YES  NO IF SO, GIVE DETAILS BELOW: \_\_\_\_\_

(CONTINUED ON PAGE 4)



Print Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

EVIDENCE OR HISTORY OF VENEREAL DISEASE: IF BLOOD SEROLOGY OR OTHER LABORATORY EXAMINATIONS ARE MADE, GIVE DETAILS BELOW:

\_\_\_\_\_  
\_\_\_\_\_

URINALYSIS (IF INDICATED):

SP. GR	_____	ALBUMEN	_____	SUGAR	_____
CASTS	_____	BLOOD	_____	PUS	_____

I HAVE FOUND THE APPLICANT ABNORMAL UNDER THE FOLLOWING HEADINGS:

\_\_\_\_\_  
\_\_\_\_\_

REMARKS (Include statement regarding examinee's fitness to perform work as a Port Pilot):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician or Examiner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician or Examiner

ADDRESS OF EXAMINING PHYSICIAN (Print):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_