

How to Complete an Application  
in the DOH 329 Registry  
Patient Application System

**Detailed Instructions**

for Patients and their Caregivers

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# What's New: Patients

- Patients now have control of all personal (i.e. name, address, grow site) AND caregiver information that is submitted to DOH.
- Patients will:
  - Create an account to access the online application
  - Login and enter their own information
  - Upload (attach) any relevant documents (e.g., photocopy of valid ID)
  - Enter/upload their caregiver's information, if applicable (a caregiver is someone OTHER THAN the patient)
  - Pay online with credit/debit card or direct withdrawal from savings or checking account (*Money Orders & Cashiers Checks will NOT be accepted for new or renewal applications*)

# What's New: Physicians

## Certifying physicians:

- Should review the information the patient entered
- May upload documents (e.g., valid ID) if needed
- May return an incomplete or incorrect application to the patient (i.e. patient entered incorrect information and needs to fix)
- May assist in completing the application
- MUST submit the electronic application to DOH  
(patients CANNOT submit applications directly to DOH)

# What's New: DOH

## DOH:

- Will review electronic applications online
- Will approve complete applications in the order received
- May correspond directly with patient for missing or incomplete information
- May return incomplete applications to either patient or physician, as applicable
- Will send 329 Registration Cards to patient (*patient will deliver to caregiver, as applicable*)

# What the PATIENT Needs to Start

- Talk to your physician to confirm that they are willing and able to certify your condition (certifying physicians must be in our system in order to submit an application on your behalf)
- Know the *exact* spelling of your certifying physician's First and Last Name
- Payment will be required so be sure you already have an appointment scheduled *(no refunds)*
- Have a clear copy of your valid ID saved to your computer so you can upload (attach) it to your application easily

# Upload vs Download

- You will be asked to **download** = that means to retrieve a document from the system such as a form (i.e. caregiver, minor, or grow site certification forms)
- Once you download the form,
  - you may want to save it to your computer (or electronic device),
  - You should check the form to be sure the form is complete – it will prefill based on what you enter into the system,
  - You must Print and Sign, as applicable
- Once the form is complete, you may scan or otherwise save the completed signed form to your computer (or other electronic device) so that you can **upload** (or attach) the document to your application
- To upload, you will be asked to “browse” your computer’s various drives. When you see the document you want to upload, click on that item and continue to “upload”.
- Once uploaded, check to be sure it is the correct document. (you can double click the item to view it once it is uploaded)
- Uploading an INCORRECT document = INCOMPLETE application and will delay processing time.

# Required Documents to UPLOAD

- Patient - NO CAREGIVER, you need a minimum of a valid ID to upload (everything else can be done electronically)
- Patient - WITH a Caregiver, you need a minimum of (the above plus):
  - Caregiver's valid ID
  - Caregiver Certification Form - *you will be prompted to print this during the application process, if applicable. It must be (downloaded) printed, signed, and uploaded before your application can be submitted to DOH*
- IF your Caregiver is associated with your grow site, you also need:
  - Grow Site Certification Form – *you will be prompted during the application process, as noted above.*

# Overview of Patient Steps

1. Create a free eHawaii.gov account by visiting <https://login.ehawaii.gov>
2. Go to <https://medmj.ehawaii.gov> to log in and begin the application
3. Before you start, read information displayed and view FAQ
4. Enter doctor's first & last name
5. Enter patient's contact & ID information
6. If applicable, enter:
  - a) Caregiver's contact & ID information
  - b) Grow site information
7. View and Download required documents
8. Name and Scan (Save) required documents
9. Upload required documents (if you are unable, your physician may be able to help do this)
- 10. Review data** – corrections requested after DOH issues the 329 Card will require a \$16.50 payment (for a replacement 329 Card) and appropriate forms
11. Electronically certify and sign by entering your name
12. Pay \$38.50 using credit card, MasterCard or VISA Debit card, or Check (no Money orders/Cashier Checks)

**You're ready for your appointment with the doctor!** Be sure to bring the required documents if you have not uploaded them.

## Step 1 – Create your free account

- Create a free eHawaii.gov account by visiting <https://login.ehawaii.gov>

eHawaii.gov Account Account Services

**Log In**  
You may log in now in order to access protected services.  
Email:  
  
Password:

**Support**  
Need an account?  
[Create Free Account](#)  
   
Forgot your password?  
[Retrieve Password](#)

Click 'Create Free Account'

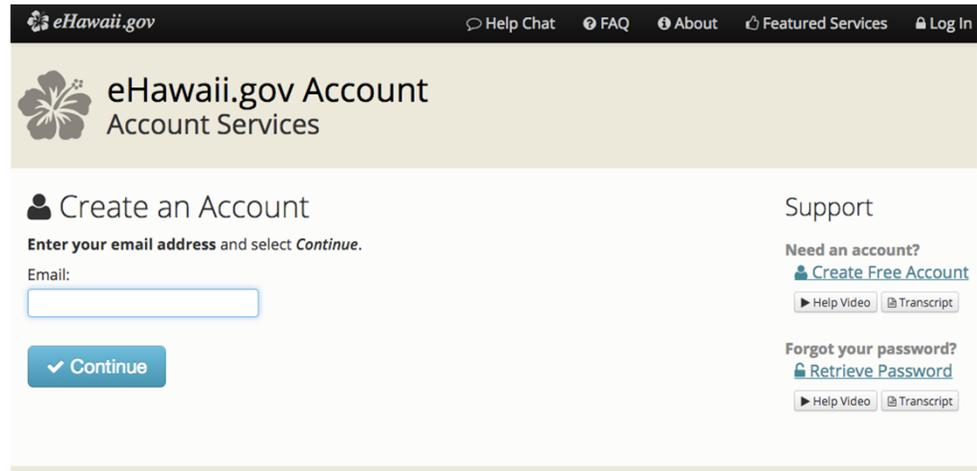
## Step 1 – Create your free account (cont'd.)

- Enter your email address and click 'Continue'.

On the next screen, provide:

- Patient name as it appears on Patient valid ID
- A Password you create
- A Password hint
- Address
- Contact number(s)
- Checkboxes for notifications

**NOTE: Be sure to REMEMBER your email address and password since you will need them to access the system**



The screenshot shows the eHawaii.gov Account Services page. At the top, there is a navigation bar with links for Help Chat, FAQ, About, Featured Services, and Log In. Below this is a header with the eHawaii.gov logo and the text 'eHawaii.gov Account Account Services'. The main content area is titled 'Create an Account' and includes the instruction 'Enter your email address and select Continue.' There is an 'Email:' label followed by a text input field and a blue 'Continue' button with a checkmark icon. To the right of the form is a 'Support' section with links for 'Need an account?' (Create Free Account) and 'Forgot your password?' (Retrieve Password), each with 'Help Video' and 'Transcript' options.

## Step 2 – Go to the Patient Application System

- Go to <https://medmj.ehawaii.gov> and login using the email address and password you created at ehawaii.gov
- There are links to help you sign up for an account (if you have not already done so) or reset your password.

### **NOTE:**

Retrieve Password = Reset Password

hawaii.gov Home Help Chat First-time Doctor Log In

### Medical Marijuana Registry Hawaii State Department of Health

**Create an Online Application in the Medical Marijuana Registry System**

Patients:

- Login with your eHawaii.gov account OR [Create a free account](#) first in order to start your online application

Doctors:

- Login with your eHawaii.gov/MyPVL account
- Doctor accessing the system for the first time? Visit [First-time Doctor Login](#)

**Log in to begin:**

Email:  Password:

[Sign up for Free Account](#) [View Sign Up Video](#) Forgot password? [Retrieve Password](#)

State of Hawaii Department of Health © 2014 All rights reserved

## Step 3 – Read Instructions and FAQ

- Read information displayed and view FAQ
- FAQ is displayed in top green band
- After reviewing, click ‘Start an Application’

**DO NOT try to renew an application more than 60 days prior to expiration of current registration.**

hawaii.gov Home Info **FAQ** Help Chat My Account Log Out

Home

### Welcome to the online patient application!

Thank you for setting up your account and logging into the Medical Marijuana Registry. **FAQ**

At this point you should have contacted the doctor who will manage your care. You will need to provide the doctor's first and last name in order to create your online application.

If this application is for a patient who is a Minor or Adult Lacking Legal Capacity, read the [Minor/Adult Lacking Legal Capacity Requirements](#).

By completing the online Patient Application and providing your doctor with the required documents, you are helping to expedite your registration and receipt of your card.

#### How does the application process work?

[Frequently Asked Questions](#)

<b>Step 1</b> → You fill out the online application form with information about the following: <ul style="list-style-type: none"><li>• patient</li><li>• caregiver (if applicable)</li><li>• grow site (if applicable)</li></ul>	<b>Step 2</b> → You pay \$38.50 via credit card or echeck and submit the online application to the doctor you've designated.	<b>Step 3</b> → The doctor reviews and submits the application to the Hawaii State Department of Health.	<b>Step 4</b> 👍 Department of Health approves the application and mails out the Registration Card.
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If you are a renewing patient, do not submit your application more than 60 days prior to expiration of current registration

**Start an Application** **To Begin**

## Step 4 – Enter doctor’s first & last name

- You should have already made arrangements to see a doctor.
- Enter the first and last name of the doctor on this screen in order to continue.
- If the name is incorrect, you can also enter the doctor’s license type (MD or DOS) and their license number

**NOTE:** You will see an error message if your physician has not yet registered on the medmj.ehawaii.gov site. In this case, please advise your physician accordingly.

The screenshot shows a web form titled "Create Application" with a "Form progress" indicator. The main section is "Medical Information". Under "Physician's Information", there is a prompt "Enter your doctor's first name & last name." followed by two input fields: "First Name:" and "Last Name:". Below these fields are two buttons: a white "Cancel" button and a green "Next" button with a right-pointing arrow.

## Step 5 – Enter Patient’s Information

Using the qualifying patient’s **valid** identification (ID) carefully fill out the patient’s full **name exactly as it appears on their valid ID.**

- Valid ID, in order of preference is driver’s license, state ID or passport.

**Minors** - For minors under age 10, if none of the previous forms of valid ID are available, the applicant may use a certified birth certificate. Enter the identification number from the certificate in the space. *Minor’s age 10 and older, please use a STATE ID.*

**Adult Lacking Legal Capacity** - check the box highlighted

**Create Application** Form progress:

### Patient Information

Enter additional Patient information. All fields are required unless otherwise noted.

**NOTE: Name entered must match name on patient identification.**

First Name:  Middle Name:  Last Name:  Suffix:

OPTIONAL OPTIONAL

Birth Date:  Gender:

Format: mm/dd/yyyy

Is the patient an adult lacking legal capacity? ⓘ

Yes, the patient is an adult lacking legal capacity

## Step 5 – Enter Patient’s Information (cont’d.)

- Remember that patient name must match what is on ID
- **NO P.O. BOXES for residential address**
- For all addresses (residence, mailing, grow site), be sure that you include the full house number, the apartment number if applicable, and the street suffix (street, road, lane, avenue).
- Email is prefilled
- You can save your information by clicking the ‘Save Application’ button
  - Continue working after saving or exit the application

**Create Application** Form progress:

### Patient Information

Enter additional Patient information. All fields are required unless otherwise noted.  
**NOTE: Name entered must match name on patient identification.**

First Name:  Middle Name:  Last Name:  Suffix:   
OPTIONAL OPTIONAL

Birth Date:  Gender:  Is the patient an adult lacking legal capacity?  Yes, the patient is an adult lacking legal capacity  
Format: mm/dd/yyyy

### Residential Address

Address Line 1:  Address Line 2:   
**IMPORTANT: Include apartment number in the Address.** OPTIONAL

City:  Island:  State:  Zip Code:

### Mailing Address:

Same as Residential Address

Address Line 1:  Address Line 2:   
**IMPORTANT: Include apartment number in the Address.** OPTIONAL

City:  State:  Zip Code:

ID #:  ID Type:  State Issued:  Expiration Date:   
Format: mm/dd/yyyy

Primary Phone:  Alternate Phone:  Email:   
Format: ###-###-#### OPTIONAL  
If you do not wish to receive an annual reminder about renewing your registration, go to [My Account](#) to edit your email settings

## Step 6.a. – Enter Caregiver’s information if applicable

- If there is a caregiver, check the caregiver box to display the screen for entering Caregiver information.
- If there is no Caregiver, click ‘Next’.

**Create Application**

Form progress:

### Caregiver Information

Does the patient have a caregiver? If not, continue to the *Next* section.

Yes, the patient has a caregiver. — Check box if there is a caregiver

< Previous Save Application > Next

**CAREGIVER = someone other than the patient!**

## Step 6.a. – Enter Caregiver’s information (cont’d.)

- Remember that caregiver name must match what is on ID
- Caregiver **cannot** be a minor
- Caregiver **cannot** be listed as caregiver in another patient’s valid record
- **NO P.O. BOXES for residential address**
- Include Apartment number for addresses
- An alternate phone and an email address are requested but not required
- **A caregiver certification must be downloaded, signed, and uploaded later in the process**
- You can save your information by clicking the ‘Save Application’ button
  - Continue working after saving or exit the application

**Create Application** Form progress:

### Caregiver Information

Does the patient have a caregiver? If not, continue to the Next section.  
\* Yes, the patient has a caregiver.

Enter additional Caregiver information. All fields are required unless otherwise noted.  
**NOTE: Name entered must match name on patient identification.**

First Name:  Middle Name:  Last Name:  Suffix:   
OPTIONAL OPTIONAL

Birth Date:  Gender:   
Format: mm/dd/yyyy

ID #:  ID Type:  State Issued:  Expiration Date:   
Format: mm/dd/yyyy

**Residential Address:**

Address Line 1:  Address Line 2:   
**IMPORTANT: Include apartment number in the Address.** OPTIONAL

City:  Island:  State:  Zip Code:

**Mailing Address:**  
\* Same as Residential Address

Address Line 1:  Address Line 2:   
**IMPORTANT: Include apartment number in the Address.** OPTIONAL

City:  State:  Zip Code:

Primary Phone:  Alternate Phone:  Email:   
Format: ###-###-#### OPTIONAL OPTIONAL

## Step 6.b. – Enter Grow Site Information if applicable

If the patient is planning to grow or is planning to have their caregiver grow the medical marijuana, this section must be completed

If there is a grow site, check the 'Yes, there is a grow site' box to display the screen for entering grow site information.

If there is no grow site, click 'Next'.

**Create Application**

Form progress:

### Grow Site

Is there a Grow Site to enter? If not, continue to the *Next* section.

Yes, there is an active Grow Site for this record. Check this box if there is an active Grow Site

< Previous Save Application Next >

**NOTE:** For Patients with NO CAREGIVER, the entire application can be certified electronically – no Grow Site Certification needs to be uploaded.

## Step 6.b. – Enter Grow Site Information (cont'd.)

Select the location of the grow site

If it is at a different address than that of the patient or caregiver the screen will display fields to enter the address or TMK – **TMK is NOT Recommended.**

Select who owns/controls the grow site. Typically, the individual that resides at the location is said to control the grow site.

You can save your information by clicking the 'Save Application' button

You can continue working after saving or exit the application

**Create Application**

Form progress:

### Grow Site

Is there a Grow Site to enter? If not, continue to the *Next* section.

Yes, there is an active Grow Site for this record.

---

**Enter additional Grow Site information. All fields are required unless otherwise noted.**

Is the Grow Site address same as the patient's or caregiver's address?

- Yes. Same as Patient's residential address.
- Yes. Same as Caregiver's residential address.
- No. I'll enter an address.
- No. I'll enter a TMK.

This grow site is controlled by the:

- Patient
- Caregiver

---

## Step 6.b. – Enter Grow Site Information (cont'd.)

If you select 'I'll enter an address', you will need to indicate if this site is under the control of the patient or the caregiver AND you will need to fill out the address in the section that displays. Be sure to include apartment number and street suffix (i.e. street, road, lane).

Be sure that you include the full house number, the apartment number if applicable, and the street suffix (street, road, lane, avenue).

**NOTE:** If you enter your grow site address incorrectly, you may not be protected.

**Create Application**

Form progress:

### Grow Site

Is there a Grow Site to enter? If not, continue to the *Next* section.

Yes, there is an active Grow Site for this record.

---

**Enter additional Grow Site information. All fields are required unless otherwise noted.**

Is the Grow Site address same as the patient's or caregiver's address?

Yes. Same as Patient's residential address.  
 Yes. Same as Caregiver's residential address.  
 No. I'll enter an address.  
 No. I'll enter a TMK.

This grow site is controlled by the:

Patient  
 Caregiver

---

Address Line 1:

Address Line 2:

**IMPORTANT: Include apartment number in the Address.** OPTIONAL

City:  Island:  State:  Zip Code:

---

## Step 6.b. – Enter Grow Site Information (cont'd.)

It is in the patient's best interest to be as specific as possible. **A complete street address is preferred**, however, if no street address is available, a Tax Map Key (TMK) and a description/directions of/to the address is required.

**Create Application**

Form progress:

### Grow Site

Is there a Grow Site to enter? If not, continue to the *Next* section.

Yes, there is an active Grow Site for this record.

---

Enter additional Grow Site information. **All fields are required unless otherwise noted.**

Is the Grow Site address same as the patient's or caregiver's address?

Yes. Same as Patient's residential address.  
 Yes. Same as Caregiver's residential address.  
 No. I'll enter an address.  
 No. I'll enter a TMK.

This grow site is controlled by the:

Patient  
 Caregiver

---

TMK:   
Format: ###-###-###-###-###-###  
#####

Description:

---

## Step 7 –View & Download Required Documents

Based on what you enter, the system will list documents that are REQUIRED in order to complete the application. Patients will have different document requirements based on what they have entered.

**ALL patients** must upload a clear copy of their VALID ID on the next screen or by the physician.

If there is a caregiver, upload a clear copy of the caregiver’s VALID ID.

Download the documents that have a ‘Get it here’ button

The patient and caregiver must sign the downloaded documents as applicable.

The documents must be uploaded to the application on the next screen or by the doctor.

The application can NOT be submitted to DOH without the REQUIRED documents.

11/12/2015

The screenshot shows a web interface titled "Create Application". At the top, there is a progress bar and the text "Form progress:". Below this is a section titled "Required Documents" in red. The text explains that the patient needs a government-issued photo ID and that a photocopy will be uploaded in the next step. It also mentions that if there is a guardian/caregiver, they need to complete and sign forms and provide a photocopy of their ID. A list of four required documents is shown: 1. Patient ID card, 2. Caregiver ID Card, 3. Caregiver Certification, and 4. Grow Site Certification. Each item has a "Get it here" button with a download icon. A purple circle highlights the "Get it here" button for "Caregiver Certification", and a purple arrow points from this button to the text "If there is a caregiver, upload a clear copy of the caregiver’s VALID ID." Below the list, there is a red warning: "IMPORTANT: Check the applicable Location box on the Grow Site Certification before initialing and signing." At the bottom of the form, there are three buttons: "Previous" (disabled), "Save Application" (active), and "Next" (active). At the very bottom, there are two file upload fields: "Grow Site Certification-12..." and "Caregiver Certification-12...", and a "Show All" button.

**NOTE: INCORRECT attachments = INCOMPLETE application, this will cause delays in processing your application.**

Patient Instructions - How to Complete an Application

# Step 8 – Name and Scan (Save) Your Required Documents

1. Name your documents – use a name that you will easily recognize. For example, if Patient = John Smith & Caregiver = Suzie Smith you can use the Form Name, Date, and the individuals Initials of who signed the form
  - Caregiver Certification Form = Caregiver.Form.SS.10.22.15
  - Caregiver ID = CaregiverID.SS.10.22.15
  - Grow Site Certification = Grow Site.Form.10.22.15
  - Patient ID = PatientID.J.S.10.22.15
2. Scan or save your documents. Before you upload/attach the required document to the application, you must first **scan** or otherwise **save** the signed/dated document to your computer or electronic device.  
***NOTE: INCORRECT attachments = INCOMPLETE application,***  
this will cause delays in processing your application.

## Step 9 – Upload Required Documents

On this screen, you will be able to browse your computer or electronic device and upload the documents you just scanned/saved.

Click 'Yes' to upload your documents.

If for some reason you cannot upload documents, bring your documents to the doctor for upload.

**If you are uploading a Grow Site Certification, remember to check the box indicating location.**

**Create Application**

Form progress:

### Upload Supporting Documents

Photocopies of identification and certain signed documents must be included when your doctor submits your application to the Department of Health. You can upload some or all photocopies now if they are ready.

If the documents are not ready, you can save the application, return later and attach them. OR, the doctor's office must upload photocopies of the IDs and the signed forms when you bring them to your appointment.

1. Patient ID card
2. Caregiver ID Card
3. Signed Caregiver Certification
4. Signed Grow Site Certification **IMPORTANT: Be sure applicable Location box on the Grow Site Certification is checked.**

Do you want to upload any required documents now?

**Yes, I want to upload documents now.**

**Check this box to upload documents or view already uploaded documents**

← Previous Save Application Next →

**WARNING:** If you upload the same type of document (e.g., Patient ID), **the system will overwrite the previous upload of the same type.** OR require that you remove the previous document before attaching a new one.

Patient Instructions - How to Complete an  
Application

## Step 9 – Upload Required Documents (cont'd.)

Each required item/document will allow only ONE attachment

Click the blue 'Select' button to open your browser and to select your document

Highlight the document you want to open and click 'open'

### Create Application

Form progress:

#### Upload Supporting Documents

Photocopies of identification and certain signed documents must be included when your doctor submits your application to the Department of Health. You can upload some or all photocopies now if they are ready.

If the documents are not ready, you can save the application, return later and attach them. OR, the doctor's office must upload photocopies of the IDs and the signed forms when you bring them to your appointment.

1. Patient ID card
2. Caregiver ID Card
3. Signed Caregiver Certification
4. Signed Grow Site Certification **IMPORTANT: Be sure applicable Location box on the Grow Site Certification is checked.**

Do you want to upload any required documents now?

Yes, I want to upload documents now.

Upload each document separately as shown below. Please verify all information and documents are correct before submitting. Errors will delay approval.

**Description of document you are uploading**

Patient ID Card : Upload a photocopy of the Patient's government issued photo ID or for a minor, a birth certificate	Upload Progress
<input type="button" value="Select File"/> <input type="button" value="Upload"/> <input type="button" value="Cancel"/>	
Caregiver ID Card : Upload a photocopy of the Caregiver's government issued photo ID	Upload Progress
<input type="button" value="Select File"/> <input type="button" value="Upload"/> <input type="button" value="Cancel"/>	

## Step 9 – Upload Required Documents (cont'd.)

hawaii.gov Home Info FAQ Help Chat My Account Log Out

### Create Application

Form progress:

## Upload Supporting Documents

Photocopies of identification and certain signed documents must be included when your doctor submits your application to the Department of Health. You can upload some or all photocopies now if they are ready.

If the documents are not ready, you can save the application, return later and attach them. OR, the doctor's office must upload photocopies of the IDs and the signed forms when you bring them to your appointment.

1. Patient ID card
2. Caregiver ID Card
3. Signed Caregiver Certification
4. Signed Grow Site Certification **IMPORTANT: Be sure applicable Location box on the Grow Site Certification is checked.**

Do you want to upload any required documents now?

Yes, I want to upload documents now.

Upload each document separately as shown below. Please verify all information and documents are correct before submitting. Errors will delay approval.

Patient ID Card : Upload a photocopy of the Patient's government issued photo ID or for a minor, a birth certificate	Upload Progress
<input type="button" value="Select File"/> <span>MedMJ Patient ID.pdf</span> <input type="button" value="Upload"/> <input type="button" value="Cancel"/>	
Caregiver ID Card : Upload a photocopy of the Caregiver's government issued photo ID	Upload Progress
<input type="button" value="Select File"/> <input type="button" value="Upload"/> <input type="button" value="Cancel"/>	
Caregiver Certification : Upload a completed, signed copy of the Caregiver's Certification	Upload Progress

Your document NAME will be displayed between the blue 'Select File' button and the green 'Upload' button

Next, click the green 'Upload' button

File is selected

2 Upload Document

## Step 9 – Upload Required Documents (cont'd.)

### Create Application

Form progress:

#### Upload Supporting Documents

Photocopies of identification and certain signed documents must be included when your doctor submits your application to the Department of Health. You can upload some or all photocopies now if they are ready.

If the documents are not ready, you can save the application, return later and attach them. OR, the doctor's office must upload photocopies of the IDs and the signed forms when you bring them to your appointment.

1. Patient ID card
2. Caregiver ID Card
3. Signed Caregiver Certification
4. Signed Grow Site Certification **IMPORTANT: Be sure applicable Location box on the Grow Site Certification is checked.**

Do you want to upload any required documents now?

Yes, I want to upload documents now.

Upload each document separately as shown below. Please verify all information and documents are correct before submitting. Errors will delay approval.

Patient ID Card : Upload a photocopy of the Patient's government issued photo ID or for a minor, a birth certificate	Upload Progress
<input type="button" value="Select File"/> <input type="button" value="Upload"/>	✓ MedMJ Patient ID.pdf
Caregiver ID Card : Upload a photocopy of the Caregiver's government issued photo ID	Upload Progress

After you have clicked 'Upload', the document NAME will display under "Upload Progress"

The red 'REMOVE' document button will also be available so you can replace the document if need be (i.e. you attached the wrong document)

File was uploaded!

Can remove if need to replace

## Step 9 – Upload Required Documents (cont'd.)

Repeat this for all of the documents that must be uploaded.

There is an 'Other Documents' option for documents that are not required.

Remember

- You should save your scanned documents in a way that makes them easily identifiable
- **If you are uploading a Grow Site Certification, remember to check the box indicating location.**
- Only one document per Required Document is allowed.

hawaii.gov Home Info FAQ Help Chat My Account Log Out

Do you want to upload any required documents now?

Yes, I want to upload documents now.

Upload each document separately as shown below. Please verify all information and documents are correct before submitting. Errors will delay approval.

**Repeat for all required documents**

Document Type	Upload Progress	Remove
Patient ID Card : Upload a photocopy of the Patient's government issued photo ID or for a minor, a birth certificate	✓ MedMJ Patient ID.pdf	Remove
Caregiver ID Card : Upload a photocopy of the Caregiver's government issued photo ID	✓ MedMJ Caregiver ID.pdf	Remove
Caregiver Certification : Upload a completed, signed copy of the Caregiver's Certification	✓ MedMJ Caregiver Certification.pdf	Remove
Grow Site Certification : Upload a copy of the Grow Site Certification that has been completed and signed by Patient and (if applicable) Caregiver	✓ MedMJ Grow Site Certification.pdf	Remove
Other Documents : (if desired)		Cancel

Other documents are optional

Previous Save Application Next

**WARNING:** If you upload the same type of document (e.g., Patient ID), **the system will overwrite the previous upload of the same type.** OR require that you remove the previous document before attaching a new one.

## Step 10 – Review Data

**Review all information on this screen and ensure it is correct.** Errors will delay processing by the DOH.

A fee of \$16.50 plus the appropriate change forms are required for any changes requested once DOH issues the 329 Card.

NOTE that in the Patient Section, the Patient Electronic Signature is blank until you electronically certify the application in the next step.

NOTE that in the Medical Information Section, the Medical Condition and Physician Certification Electronic Signature are blank until the doctor electronically certifies the application after the patient pays and before the application can be submitted to DOH.

**Create Application** Form progress: [Progress Bar]

**Review**

Application Number: 121888

**Registration Details** Show/Hide All

**Patient Information**

Name:	testpatient47 testname47	Date of Birth:	10/10/1990	Gender:	Male
ID #:	h123	State Issued:	HAWAII	ID Type:	Driver's License
				Expiration:	11/11/2016
Residential Address:	1 test ave, Honolulu, HI 96813		Island:	Oahu	Mailing Address: SAME
Phone:	8765434567	Alt. Phone:	7654456789	Email:	testpatient47@gmail.com
Minor (Based on Today's Date):	No	Adult Lacking Legal Capacity:	No	<b>Patient Certification Electronic Signature:</b>	

**BLANK UNTIL PATIENT CERTIFIES**

**Caregiver Information**

Name:	testcare testgiver	Date of Birth:	10/10/1990	Gender:	Male
ID #:	h321	State Issued:	HAWAII	ID Type:	Driver's License
				Expiration:	11/11/2016
Residential Address:	3 test ave, Honolulu, HI 96813		Island:	Oahu	Mailing Address: SAME
Phone:	8765432456	Alt. Phone:	8765432345	Email:	testcare@test.com
<b>BLANK UNTIL DOCTOR CERTIFIES</b>					

**Medical Information**

<b>Medical Conditions:</b>	<b>Physician Certification Electronic Signature:</b>				
Physician's Name:	John Doe				
Title:	MD	Medical License #:	123	Expiration Date:	00/00/0000
Controlled Substance #:	123	Expiration Date:	00/00/0000		

## Step 11 – Patient Certification

Read the Applicant Statement

Check the 'I agree' box and click 'Enter' to activate the Continue button

**APPLICANT STATEMENT OF UNDERSTANDING AND CERTIFICATION**

I CERTIFY that:

1. I have read, understand, and agree to part IX, chapter 329, Hawaii Revised Statutes (HRS): Medical Use of Marijuana;
2. I have a debilitating medical condition(s), as defined therein, and as stated in section C of this application;
3. My use of marijuana is solely for the treatment of the specified debilitating medical condition;
4. I agree to abide by the Conditions of Use as outlined in part IX, section 329-122, HRS, as well as ALL other applicable sections of part IX, chapter 329, HRS.
5. I plan to grow (or NOT grow) my medical marijuana, as indicated on online.
6. If I've indicated a grow site location other than my residence (an "Other Address") AND I've indicated that I either own or control the "Other Address", as evidenced by my initials where applicable, I attest that I either own or control the stated grow site location.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding the medical use of marijuana, I may not be protected against arrest, prosecution, or conviction under Federal law.

**CONSENT TO RELEASE INFORMATION**

I consent to allow my primary care physician, so named in this application, to release any protected health information pertaining to my debilitating medical condition for the purpose of my registration for medical use of marijuana as set forth in part IX, chapter 329, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of my medical use of marijuana registration card or upon my written revocation of this consent. I understand that if I revoke my consent, my medical use of marijuana registration card will be revoked.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that my registration as a qualified patient to use medical marijuana under Hawaii law may not protect me against arrest, prosecution, or conviction under Federal law.

I agree

Signature: **NOTE: Electronic signature provided below must exactly match patient name on application.**

testpatient47 testname47

**Check 'I agree' box and click Enter to activate 'Continue' button**

## Step 12 - Payment Method = Payment Options

Payment options are:

- Credit/Debit Card – has the fastest turnaround time and/or no delay for the issue of the card once the signed application is received and verified by DOH.
- Electronic Debit from Checking/Savings Account – there may be some delay as DOH will not issue the card until the payment has had time to clear your account or a minimum of 10 business days from the electronic submittal & verification of the signed application by DOH.

## Step 12 – Select a Payment Method

**Payment Options** will display in the dropdown for **Payment Method**

Electronic payment by credit/debit card or direct withdrawal from a savings or checking account are accepted

MONEY ORDERS or CASHIER CHECKS will NOT be accepted

Select a payment method and click 'Submit'

**SEE next few slides about Payment Options/Payment Methods**

- a) Debit/Credit Card payments
- b) eCheck payment (direct debit from checking or savings account)

The screenshot shows a web application interface for selecting a payment method. At the top, there is a section titled "Uploaded Supporting Documents" with four items: Patient Id Card (MedMJ Patient ID.pdf), Caregiver Id Card (MedMJ Caregiver ID.pdf), Caregiver Certification (MedMJ Caregiver Certification.pdf), and Grow Site Certification (MedMJ Grow Site Certification.pdf). Below this is a blue bar stating "Payments are non-refundable". A table with columns "Line", "Description", and "Amount" shows one line item: "1 New Application for testname47, testpatient47" with an amount of "\$38.50". Underneath the table is a "Payment Method:" dropdown menu with options: "-Select-", "Credit Card", "MasterCard Debit Card", "VISA Debit Card", and "eCheck". A "Submit" button is visible at the bottom right.

**WARNING**: All application fees are non-refundable, even if a card is NOT issued.

## Step 12 – Payment Method

In this next phase of the process, payment, the steps are different based on the type of payment by the patient.

The amount that must be paid is \$38.50 – **regardless of payment type**. **All payments are nonrefundable.**

The next slides focus on:

- a) Debit/Credit Card payments
- b) eCheck payment (direct debit from checking or savings account)

Medical Marijuana Registry | Help Chat | My Account | Log Out

Record Details | Show/Hide All

**▲ Patient Information**

Name: a a	Date of Birth: 10/27/1111	ID #: 123	State Issued: Arizona	Expiration: 11/04/1111
Residential Address: 1 test ave, Honolulu, Oahu HI 11111	Mailing Address: SAME			
Phone: 1111111111	Alt. Phone:	Email:		

**▼ Caregiver Information**

**▼ Medical Information**

**▼ Grow Site**

Line	Description	Amount
1	New Record for a, a	\$38.50

Payment Method:

**WARNING**: All application **fees are non-refundable**, even if a card is NOT issued.

## Step 12.a. – Debit/Credit Card Payment

At this point, you have selected via the dropdown that the form of payment is either a Debit Card or Credit Card.

**Click the Submit button at the bottom of the screen.**

You will be paying as described on the pages that follow.

The screenshot shows a web browser window with the URL <https://test-medmj.ehawaii.gov/medmj/doctor/create-review.html>. The page title is "Create New Record" and it is in "Review" mode. The form contains the following sections:

- Patient Information:**

Name: HONOLULU	Sex: F	Date of Birth: 11/11/1998	Gender: Female
SSN: 234234	MRN: 987654321	State Issue: Hawaii	Expiration: 11/11/2015
Residential Address: 7001 Ala Moana Blvd, Honolulu, HI 96813	Work Address: SAAB	Phone: 808-555-1234	
- Caregiver Information:** (Collapsed)
- Medical Information:** (Collapsed)
- Charges:**

Line	Description	Amount
1	Exam Record for visit, HONOLULU	638.50

At the bottom, there is a "Payment Method" dropdown menu set to "Bank" and a green "Submit" button.

**WARNING**: All application **fees are non-refundable**, even if a card is NOT issued.

## Step 12.a. – Debit/Credit Card Payment

If payment is via Debit or Credit Card, you will need to follow the directions below.

The screen to the right displays after you click 'Submit'.

In the Contact Information Section, enter the Patient name, email and phone number, unless the patient is a minor. If the patient is a minor, enter caregiver name, email, and phone.

In the Credit Card Information Section, Enter the name on the credit or debit card (note that only MasterCard and VISA debit cards are accepted), the type of card, the number, and the expiration month and year.

In the Billing Address section, enter the billing address of the card holder.

Click Continue.

The screenshot shows the 'Credit Card Payment' form on the Hawaii.gov website. The form is titled 'Credit Card Payment' and includes a lock icon in the top right corner. Below the title, it states 'All fields are **required** unless otherwise noted.' and shows a 'Total Payment: \$38.50' with a 'View Details' link. The form is divided into three main sections: 'Contact Information', 'Credit Card Information', and 'Billing Address'. The 'Contact Information' section has fields for Name, Email Address, and Phone Number, with a note that the email is used for receipts and payment notifications. The 'Credit Card Information' section includes fields for Cardholder Name (with a 50-character limit), Card Type (with radio buttons for VISA, MasterCard, Discover, and American Express), Card Number, and Expiration Date (with dropdown menus for Month and Year). The 'Billing Address' section has fields for Address Line 1, Address Line 2, City, State (with a dropdown menu showing 'Hawaii'), Zip Code, and Country (with a dropdown menu showing 'United States'). A 'Continue' button is located at the bottom of the form.

## Step 12.a. – Debit/Credit Card Payment Confirmation

Confirm that the information provided is correct.

If it is not, click the Back button at the bottom of the screen.

If it is, click the Pay Now button.

**Confirm Payment** 

Total Payment: \$38.50 [View Details](#)

Payment Information	
Contact Name	testa testa
Phone Number	808-888-8888
Email Address	test@test.com
Card Type	Visa
Account Number (last 4)	0000
Expiration Date	**/**
Name on Card	TEST TESTA
Billing Address	1 test ave honolulu, HI 96813 United States

Please Confirm	
By clicking <b>Pay Now</b> below, I certify that I am authorized to make this payment and I authorize the Hawaii Information Consortium to charge this account in the amount of <b>\$38.50</b> .	

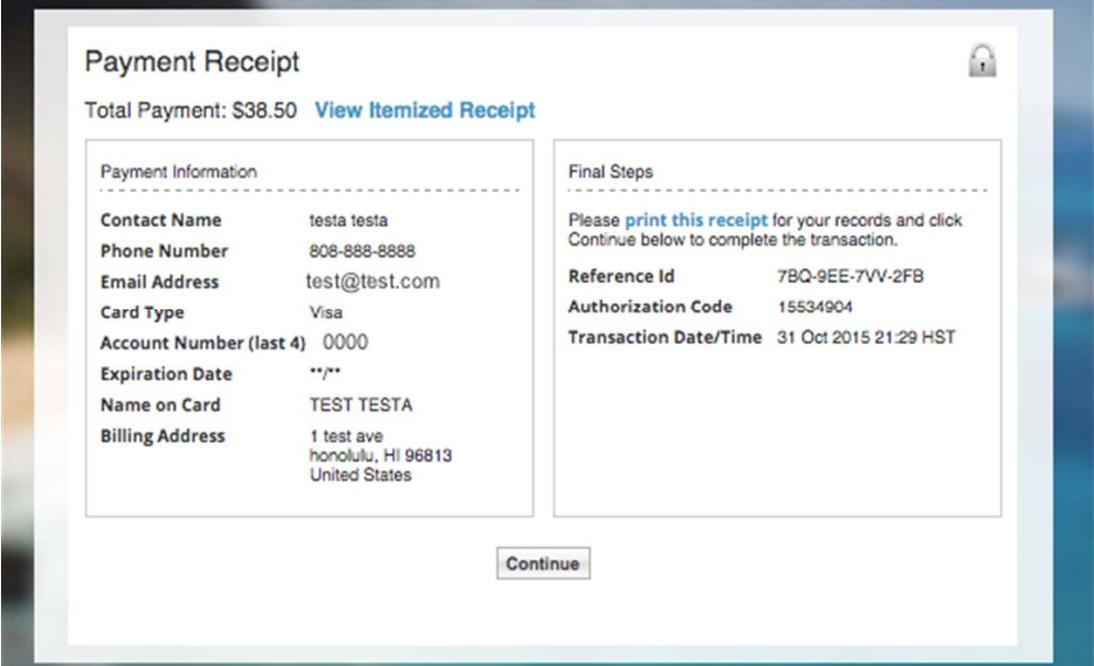
**WARNING**: All application **fees are non-refundable**, even if a card is NOT issued.

## Step 12.a. – Debit/Credit Card Payment Receipt

A payment receipt displays and can be printed, but is also sent to the email address provided on the previous payment screen.

**VERY IMPORTANT**: Click Continue to return to the **Final Version** of the Application (Thank You screen) and to print the final version if desired for your records.

**NOTE**: You will be able to view your submission at any time using your email and password via <https://medmj.ehawaii.gov>



The screenshot shows a "Payment Receipt" screen with a lock icon in the top right corner. Below the title, it states "Total Payment: \$38.50" and includes a link "View Itemized Receipt". The screen is divided into two main sections: "Payment Information" and "Final Steps".

Payment Information	
Contact Name	testa testa
Phone Number	808-888-8888
Email Address	test@test.com
Card Type	Visa
Account Number (last 4)	0000
Expiration Date	**/**
Name on Card	TEST TESTA
Billing Address	1 test ave honolulu, HI 96813 United States

Final Steps	
Please <a href="#">print this receipt</a> for your records and click Continue below to complete the transaction.	
Reference Id	7BQ-9EE-7VV-2FB
Authorization Code	15534904
Transaction Date/Time	31 Oct 2015 21:29 HST

At the bottom center of the screen is a "Continue" button.

**WARNING**: All application **fees are non-refundable**, even if a card is NOT issued.

## Step 12.b. – eCheck (Electronic Debit from Checking or Savings)

For electronic debits from checking or savings accounts, you will need to follow the directions below.

In the Contact Information Section, enter the Patient name, email and phone number, unless the patient is a minor. If the patient is a minor, enter caregiver name, email, and phone.

In the Notice Section, confirm that the bank the check is written on is a U.S. Bank by checking the box. **Payment is only accepted from U.S. banks.**

In the Account Information Section, select Business or Personal account. If Personal, select Checking or Savings account. Enter the name of the bank, the routing number (twice) - the screen provides help on this, and the name of the Account Holder. Enter the Account Number twice – again, the screen provides help for this.

In the Billing Address section, enter the address of the account holder..

Click Continue.

**WARNING:** If Electronic debit is returned , there will be a \$25 fee and the application will not be approved.

**Check Payment**  
All fields are **required** unless otherwise noted.

Total Payment: \$38.50 [View Details](#)

**Contact Information**

Name:  Email Address:   
Your email address is used to send you a receipt or to notify you of payment problems.  
It will not be used for any other purpose and we will not sell, exchange or otherwise provide your email address to any third party.

Phone Number:   
Area code required

**Notice**

eHawaii.gov does not accept International ACH Payments. Funds must originate from a US financial institution.  
 Check here if your check payment uses a US financial institution.

**Account Information**

Bank Customer Type:  Bank Account Type:   
Select... Select...

Bank Name:  Maximum 50 characters  
[Help with Routing and Account Numbers](#)

Routing Number:  Re-enter Routing Number:   
Always 9 digits

Account Holder's Name:  Maximum 22 characters

Account Number:  Re-enter Account Number:   
Up to 17 digits

**Billing Address**

Address Line 1:   
Street address, P.O. box, company name, c/o

Address Line 2:   
Optional: apartment, suite, unit, building, floor, etc.

City:  State:  Hawaii

Zip Code:

[Continue](#)

## Step 12.b. – Confirm eCheck Payment

Confirm that the information provided is correct.

If it is not, click the Back button at the bottom of the screen.

If it is, click the Pay Now button.

Confirm Payment 

Total Payment: \$38.50 [View Details](#)

Payment Information	
Contact Name	testa testa
Phone Number	808-888-8888
Email Address	test@test.com
Account Type	Personal
Account Type	Checking
Bank Name	testbank
Routing Number	*****0000
Name on Account	testa testa
Account Number (last 4)	****4321
Billing Address	1 test ave honolulu, HI 96813 United States

**Please Confirm**

Please be careful to enter the correct information for your check. Insufficient funds or incorrect routing and account numbers will result in a bounced check fee.

By clicking **Pay Now** below, I certify that I am authorized to make this payment and I authorize the Hawaii Information Consortium to charge this account in the amount of **\$38.50**.

**WARNING**: All application **fees are non-refundable**, even if a card is NOT issued.

## Step 12.b. – eCheck Payment Receipt

A payment receipt displays and can be printed, but is also sent to the email address provided on the previous payment screen.

Click Continue to return to the **Final Version** of the Application (Thank You screen) and to print the application, if desired.

**NOTE:** You will be able to view your submission at any time using your email and password via <https://medmj.ehawaii.gov>

Hawaii State Department of Health

### Payment Receipt

Total Payment: \$38.50 [View Itemized Receipt](#)

Payment Information	
Contact Name	testa testa
Phone Number	808-888-8888
Email Address	test@test.com
Account Type	Personal
Account Type	Checking
Bank Name	testbank
Routing Number	*****0000
Name on Account	testa testa
Account Number (last 4)	*****4321
Billing Address	1 test ave honolulu, HI 96813 United States

Final Steps	
Please <a href="#">print this receipt</a> for your records and click Continue below to complete the transaction.	
Reference Id	6AB-6TB-3NM-6EM
Authorization Code	15534996
Transaction Date/Time	31 Oct 2015 22:06 HST
This receipt is a record that you have submitted your check payment. Please note that your payment may take several days to clear your bank. If your check fails to clear for any reason, including incorrect routing or account numbers, you will be responsible for a bounced check fee.	

[Continue](#)

# View Thank you screen

Congratulations! You have completed your portion of the electronic application. The next step is to see your physician.

As mentioned earlier, you should have already discussed this treatment option with the physician that is treating you for this condition and scheduled an appointment with either the physician that is currently treating you for this condition or another eligible physician that is willing and able to certify your condition for the Medical Marijuana Registry Program.

Once your application is received by DOH, the application will be reviewed and, if in order, approved. DOH will mail the approved 329 Card directly to the patient.

**INCOMPLETE applications will be returned** to either the patient or the physician, as applicable.

**Thank you** Print

Application Number: XXXXX

Registration Details Show/Hide All

**Patient Information**

Name:	testpatient47 test47	Date of Birth:	10/10/1990	Gender:	Female		
ID #:	h123	State Issued:	COLORADO	ID Type:	Driver's License	Expiration:	11/11/2016
Residential Address:	1 test ave, Honolulu, HI 96813		Island:	Oahu	Mailing Address:	SAME	
Phone:	1234545678	Alt. Phone:	2345676545	Email:	XXXXXXXXXXXX@hawaii.gov		
Minor (Based on Today's Date):	No	Adult Lacking Legal Capacity:	No	Patient Certification Electronic Signature:	testpatient47 test47		

**Caregiver Information**

Name:	testcare testgiver	Date of Birth:	10/10/1990	Gender:	Male		
ID #:	h321	State Issued:	HAWAII	ID Type:	Driver's License	Expiration:	11/11/2016
Residential Address:	3 test ave, Honolulu, HI 96813		Island:	Oahu	Mailing Address:	SAME	
Phone:	7897896545	Alt. Phone:	5645613213	Email:	testcare@test.com		

**Medical Information**

Medical Conditions:

Physician's Name:	XXXXXXXXXXXX	Physician Certification Electronic Signature:					
Title:	MD	Medical License #:	XXXXXXXXXXXX	Expiration Date:	XXXXXXXXXX		
Controlled Substance #:	XXXXXXXXXX	Expiration Date:	XXXXXXXXXX				
Business Address:	XXXXXXXXXXXX, Honolulu, HI 96813		Island:	Oahu	Mailing Address:	SAME	
Phone:	XXXXXXXXXX	Alt. Phone:	XXXXXXXXXX				

# If you make a mistake .....

## What you can do if ....

- YOU find an error on your electronic APPLICATION – you can have your physician return the application to you for corrections.
- YOUR physician finds an error on your electronic APPLICATION – your physician can return the application to you for corrections.
- *If the error is missed and DOH issues the 329 Card, a replacement fee of \$16.50 and applicable forms will be required*

## Typical Errors that cause delays:

- Patient/Caregiver Name spelled wrong, wrong date of birth, wrong ID #, wrong ID expiration date, Invalid ID, changing ID type (this is not an error per se, but will cause delays while staff pull the old record to validate)

## Typical Errors that can invalidate protection:

- Grow Site Address incomplete, missing apartment number, missing street suffix (street, lane, highway, road, etc.)

Thank you for learning about  
the DOH 329 Registry  
Patient Application System!