



**STATE OF HAWAII**  
**DEPARTMENT OF HEALTH**  
 4348 Waiālae Avenue, #648  
 Honolulu, Hawaii 96816



## Medical Marijuana Registry Program

In accordance with Hawaii Revised Statutes 329-123 (b) “Qualifying patients shall report changes in information within ten working days.” This form must be signed by the registered patient or by the appropriate parent, guardian, or legal custodian, as applicable, if the registered patient is a minor or adult lacking legal capacity. The changes below will require a NEW 329 REGISTRATION CARD to be issued and a fee of \$16.50 to be paid. Please enclose a \$16.50 Cashier’s Check OR Money Order made payable to: Department of Health. **Incomplete Forms will be returned.**

### 329 – Request for a Replacement Card

I would like to request a replacement card(s) for the 329 Registration Card #: \_\_\_\_\_

**Patient Name as it appeared on the 329 Registration Card that is being replaced**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Caregiver Name as it appeared on the 329 Registration Card that is being replaced (if applicable)**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**REQUIRED SUPPORTING DOCUMENTATION**

- A copy of the valid ID that was used to register the PATIENT clearly showing the individual’s name, photo, and expiration date. (Required)

**NOTE:** Requesting a replacement card will invalidate the existing card for BOTH the patient and the caregiver. Only the registered PATIENT can request a replacement card(s). Only one fee of \$16.50 is required, even if there is a caregiver.

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, chapter 11-160, HAR, 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.

Print Patient (or Legal Guardian) Name	Patient (or Legal Guardian) Signature	Date
Print Caregiver Name (if applicable)	Caregiver Signature (if applicable)	Date