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

Medical Cannabis 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. It is your responsibility to notify your certifying physician of any changes to your information.

If the packet is incomplete or inconsistent it will be returned.

329 Change Form Packet

Only the Registered Applicant/Patient Can Request Changes

Section 329

This REQUEST is for the 329 Registration Card #:
OR 6 digit Application #: _____

Applicant Name: ***as it appears on my current 329 Registration Card***

First Name: _____ Middle Name: _____ Last Name: _____

Current Caregiver Name (if applicable): ***as it appears on my current 329 Registration Card***

First Name: _____ Middle Name: _____ Last Name: _____

THIS IS A REQUEST TO (select ALL that apply and fill out all corresponding sections:

- ☐ **1. Request a Replacement 329 Card** (lost, stolen, or damaged)
- ☐ **2. Void 329 Card**
- ☐ **3. Name and/or Date of Birth Change**
- ☐ **4. Add or Update Applicant's Contact Information**
- ☐ **5. Add or Update Caregiver's Contact Information**
- ☐ **6. Add, Change, or Remove my Caregiver**
- ☐ **7. Add, Change, or Remove Grow Site**

1. Request a Replacement 329 Card

☐ Yes ☐ No: My card has been lost, stolen, or damaged. Please reissue my 329 card.

2. Void 329 Card

Select one of the following below:

- ☐ The applicant no longer has a debilitating condition
- ☐ The applicant has a firearm permit
- ☐ Applicant is no longer benefiting from the use of medical cannabis
- ☐ The applicant is moving out of state
- ☐ The applicant will be applying for a firearm permit
- ☐ Other (please describe): _____

*If the patient is deceased, the certifying physician must fill out a separate form: "Void Request by Physician"

Mail your completed packet to: Medical Cannabis Registry, 4348 Waialae Ave, #648, Honolulu, HI 96816

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3. Name and/or Date of Birth Change

Patient Name as it will appear on the NEW Registration Card (MUST be *exactly* as it appears on the supporting ID)

First Name: _____ Middle Name: _____ Last Name: _____

Patient Date of Birth from:_____ Change Patient Date of Birth to:_____

Current Caregiver Name (if applicable): as it will appear on the NEW Registration Card (MUST be *exactly* as it appears on the supporting ID) editing your caregivers name in this section does not mean you are adding or changing your caregiver.

First Name: _____ Middle Name: _____ Last Name: _____

Caregiver Date of Birth from:_____ Change Caregiver Date of Birth to:_____

4. Add or Update Applicant's Contact Information

Select and make changes to all that apply below

☐ **Update Residence Address to:** _____

☐ **Update Mailing Address To:** _____

☐ **Update Phone Number to:** _____

☐ **Update Email Address to:**

***Please see the appendix for updating an applicant's email address.**

5. Add or Update Caregiver's Contact Information

Caregiver's Name (as stated on their ID)_____

Select and make changes to all that apply below

☐ **Update or Add Residence Address to:** _____

☐ **Update or Add Mailing Address To:** _____

☐ **Update or Add Phone Number to:** _____

☐ **Update or Add Email Address to:** _____

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6. Add, Change, or Remove a Caregiver

Select one of the following options below:

☐ Add a Caregiver (no previous caregiver).

☐ Change my caregiver. I revoke my current caregiver (listed below) and designate the following individual (listed below) as my new primary caregiver.

☐ Revoke my caregiver. I will not designate a new caregiver.

I hereby revoke my current designation of:

First Name _____ Middle Name _____ Last Name _____

Caregiver Name exactly as it appears on the 329 Registration Card

I would like to designate the following individual as my primary caregiver for the medical use of cannabis:

First Name _____ Middle Name _____ Last Name _____

New Caregiver's name must be exactly as it appears on their government issued identification card.

Valid Photo ID Required. Complete identification information below if adding or changing your caregiver.

☐ Driver's License ☐ State Identification ☐ Passport Book

State or Country of issue: _____ ID Number: _____

Expiration Date: _____ Gender: ☐ Male, ☐ Female,

Date of Birth: _____ ☐ Transgender: Male to Female

☐ Transgender: Female to Male

7. Add, Change, or Remove Grow Site

Select one of the following options below:

☐ Add a grow site (no previous grow site).

☐ Change the current grow site to a new grow site.

☐ Remove the current grow site on my 329 registration card (no new grow site).

Select one of the following options below:

☐ Applicant/Patient will grow own medical cannabis

☐ Primary Caregiver will grow medical cannabis for the Applicant/Qualifying Patient

☐ Neither Applicant/Qualifying Patient NOR primary caregiver will grow medical cannabis

The **NEW** site is owned or controlled by the **PATIENT** and is the:

(Patient must initial one of the following, if applicable)

_____Patient's residence address, *OR*

_____Patient's residence address, and mailing address, *OR*

_____Patient's Other address

OR the **NEW** site is owned and controlled by the **CAREGIVER** and is the:

(Caregiver must initial one of the following, if applicable)

_____Caregiver's residence address, *OR*

_____Caregiver's residence address and mailing address, *OR*

_____Caregiver's Other address

NEW Grow Site Address: _____

(if applicable) _____

Medical Cannabis Registry Program

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329A. APPLICANT'S 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 Cannabis;
2) I have a debilitating medical condition(s), as defined therein, and as stated in section C of this application;
3) My use of cannabis 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; chapter 11-160 HAR, and all other applicable laws for the medical use of cannabis in the State of Hawaii.

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 cannabis in the State of Hawaii. I understand that my registration as a qualified patient to use medical cannabis under Hawaii law may not protect me against arrest, prosecution, or conviction under Federal law.

Print Applicant (or Legal Guardian) Name | Applicant (or Legal Guardian) Signature | Date | Phone Number

6A. NEW 329 CAREGIVER'S STATEMENT OF UNDERSTANDING AND CERTIFICATION

I CERTIFY that :

1) I have read and understand part IX, chapter 329, HRS: Medical Use of Cannabis;
2) I agree to undertake responsibility for managing the well-being of the qualifying patient, so named as the applicant on this application, with respect to the medical use of cannabis;
3) 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, chapter 11-160, HAR, and all other applicable laws for the medical use of cannabis in the State of Hawaii; and
4) I understand that in accordance with part IX, chapter 329, HRS, medical cannabis can only be grown at one location, as designated in Section E of this application.

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 cannabis in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding primary caregivers of medical cannabis patients, I may not be protected against arrest, prosecution, or conviction under Federal law.

Print Caregiver Name | Caregiver's Signature | Date | Phone Number

Medical Cannabis Registry Program

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7A. GROW SITE CERTIFICATION

APPLICANT'S STATEMENT OF UNDERSTANDING AND CERTIFICATION *(This section **MUST** be signed by applicant, regardless of intent to grow. If applicant is a minor or adult lacking legal capacity, this section **MUST** be signed by the parent, guardian or legal custodian, as applicable)*

I, the **applicant**/qualifying patient, CERTIFY that :

1. I plan to grow (or NOT grow) my medical cannabis, as indicated on the previous page.

2. 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, chapter 11-160, HAR, and all other applicable laws for the medical use of cannabis in the State of Hawaii. I understand that my registration as a qualified patient to use medical cannabis under Hawaii law may not protect me against arrest, prosecution, or conviction under Federal law.

Print Applicant (or Legal Guardian) Name	Applicant (or Legal Guardian) Signature	Date

CAREGIVER'S STATEMENT OF UNDERSTANDING AND CERTIFICATION *(**MUST** be signed by primary caregiver IF designated to grow **or** IF primary caregiver either owns or controls the grow site location)*

I, the primary **caregiver**, CERTIFY that :

1. I understand and acknowledge that:

(Select one of the following below)

☐ I have been designated to grow medical cannabis by the aforementioned qualifying patient, OR

☐ The qualifying patient will grow on a site that I own or control; AND

2. If I've indicated a grow site location other than my residence AND I've indicated that I either own or control the "Other Address", as evidenced by my initials above, I ATTEST **that I either own or control the stated grow site location**.

3. If I've indicated a grow site location that I own or control, I am responsible for ensuring that the grow site location remains compliant with part IX, chapter 329, HRS, specifically any limitations to "adequate supply".

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 cannabis in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding the medical use of cannabis, I may not be protected against arrest, prosecution, or conviction under Federal law.

Print Caregiver's Name	Caregiver's Signature	Date

Attachments:

Payment is required for the following changes:

- **Request a Replacement 329 Card** (lost, stolen, or damaged)
- **Name and/or Date of Birth Change**
- **Add, Change, or Remove my Caregiver**
- **Add, Change, or Remove Grow Site**

Please staple payment here. The fee is $16.50 per change form, payable to “DOH” by either money order or cashier’s check. We do not accept personal checks.

Please attach a copy of applicant’s photo ID here:

Please attach a copy of caregiver's photo ID if applicable:

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Updating Patient Email Address for your Medical Cannabis Registry Login

If you have requested to update your email address, program staff will make the requested updates in your record. However, Please be advised that this does not change your Medical Cannabis Registry login information at https://medmj.ehawaii.gov. In order to update your login information to use your new email address, please follow the steps below.

1. **Go to https://login.ehawaii.gov and login using your OLD email address and current password**
2. **Click "My Account" in the top right corner- a drop down list will appear**
3. **Choose the "Update Account" option**
4. **Scroll down to Contact Information and input your new email address**
5. **Click "Save"**

You may also call our IT Help desk at 808-695-4620 for assistance. If you have any further questions or concerns please feel free to email our program at medicalcannabis@doh.hawaii.gov.