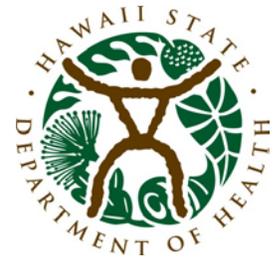




STATE OF HAWAII
DEPARTMENT OF HEALTH
 4348 Waiālae Avenue, #648
 Honolulu, Hawaii 96816



Medical Cannabis Registry Program

Personal Verification Request

Name: *as it appears on your government issued I.D.*

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

Date of Birth: _____ 329 Card OR Blue Card number: _____

1. I would like the Department of Health, Medical Cannabis Registry Program to verify that I was a registered:
 Patient OR Caregiver

2. Date I was registered: _____

OR enter a date range. From: _____ To: _____

3. I would also like the Department of Health, Medical Cannabis Registry Program to verify that my grow site on the date or date range stated above was:

Enter Grow Site Address: _____

4. Please send my personal verification response to the last known mailing address on record, OR
 Please send my personal verification response to the last known email address on record

- *All personal verification responses will be sent to the last known email or mailing address on record.*
- *If you would like the information released to another individual or entity, please fill out the Consent to Release Information form.*
- *If your mailing address has changed, please fill out the CBD-329 The Change Form Packet.*

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 request. 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.

APPLICANT'S SIGNATURE (must be a handwritten signature)

DATE

Please print, complete, and submit this request via Postal mail to: 4348 Waiālae Avenue, #648, Honolulu, Hawaii 96816 OR email to medicalcannabis@doh.hawaii.gov. **A copy of the valid ID that you used to register MUST accompany your request.**

Incomplete requests will be returned