STATE OF HAWAII
DEPARTMENT OF HEALTH
4348 Waialae 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 Waialae 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