



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



**Office of Medical Cannabis Control and Regulation - Patient Registry Program**  
**Electronic Signature Agreement**

Certifying Physician’s/Advance Practice Registered Nurse’s (APRN) Name: \_\_\_\_\_

Certifying Physician’s/APRN’s Valid Medical License # \_\_\_\_\_

Certifying Physician’s /APRN’s Valid Controlled Substance License # \_\_\_\_\_

Certifying Physician’s/APRN’s Email Address: \_\_\_\_\_

Certifying Physician’s/APRN’s Phone Number: \_\_\_\_\_

Certifying Physician’s/APRN’s Business Address: \_\_\_\_\_

As part of its Medical Cannabis Registry Program, the State of Hawaii, Department of Health has established an electronic data entry system for the registration of qualifying patients in the Medical Cannabis Registry. By signing this Agreement below, I agree that I explicitly understand, acknowledge, and affirm that my electronic signature on all applications and certifications that I submit electronically has the full force and effect of my handwritten signature, and that when I use my electronic signature in the Medical Cannabis Registration process I agree with all of the statements made in the application and the certification and any other documents I submit as part of the registration process as if I had signed those documents in my own handwriting. By signing below, I further agree to the following:

1. I understand that the Department of Health will keep this written Agreement and my handwritten signature on file for future reference and that it will not expire or otherwise terminate unless I submit a written request to revoke this Agreement and the Department of Health acknowledges my request in writing.
2. I understand that revoking this electronic signature agreement in writing or effectively revoking the electronic signature agreement by virtue of terminating the practice of medicine for any reason, including loss of license or death, the presence of my electronic signature on a previously issued 329 card will be valid until the expiration of the card, and the Department of Health is authorized to use the my electronic signature to create a replacement 329 card so long as the original certification is still valid. Nothing about this provision would authorize the use of my signature for any other reason after it is expressly or effectively revoked, nor would it authorize the use of my signature to replace a 329 card for which I have revoked the certification.
3. I authorize the Department of Health to print my name on each of my patients' Medical Cannabis Registration cards, and I agree that my printed name will serve as my electronic signature on the Medical Cannabis Registration card and will mean that I have provided the Department of Health with my electronic certification that in my professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of cannabis would likely outweigh the health risks for the qualifying patient.
4. I understand that I am bound by all of the legal requirements of chapter 329, Hawaii Revised Statutes, and chapter 11-160, Hawaii Administrative Rules, governing the Medical Use of Cannabis.
5. I understand that if either the Department of Health or I revoke this Agreement, I will no longer be allowed to submit electronic applications in the electronic data entry system for the registration of my patients in the Medical Cannabis Registry and I may not be allowed to submit any other form of application.
6. I understand that the Department of Health may share a copy of this Agreement with law enforcement personnel, court personnel, or others for law enforcement or other appropriate purposes as determined by the Department of Health.
7. I understand that it is illegal for me to allow anyone else to have access to my electronic signature or my password that allows me to certify patients for the Medical Cannabis Registry and I agree that any use of my electronic signature means I have personally authorized its use for this purpose.

\_\_\_\_\_  
 Certifying Physician’s/APRN’s Signature

\_\_\_\_\_  
 Date



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**Office of Medical Cannabis Control & Regulation**

**Patient Registry - Email delivery of the Physician/APRN Letter**

OMCCR – Patient Registry will email you a list of your patients whose applications have been recently approved by our program for your records. The letter does include confidential information and will be sent secured. Should you have any questions or concerns please contact the OMCCR Patient Registry at [medicalcannabis@doh.hawaii.gov](mailto:medicalcannabis@doh.hawaii.gov) or at 808-733-2177.

**Physician/APRN Contact Information**

Physician/APRN Name: \_\_\_\_\_

**Please select one of the following email delivery methods for the physician/APRN letter:**

Opt-out of receiving the letter (I understand I will not be receiving a hard copy letter in the mail, nor an email copy of the letter); or

Email to my email on record \_\_\_\_\_; or

Email to both my email on record and my alternative email provided below:

\_\_\_\_\_

**\*If you are providing an alternative email, registry staff will send a test email to verify the address. Please respond that you received it asap.**

**Please return the following forms via U.S. postal mail:**

1. **Electronic Signature Agreement**
2. **Email Delivery of the Physician/APRN Letter**

**Mailing Address:**

DOH-OMCCR-Patient Registry  
 4348 Waiialae Ave, #648  
 Honolulu, HI 96816

\_\_\_\_\_  
 Certifying Physician's/APRN's Signature

\_\_\_\_\_  
 Date