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.

329A. APPLICANT'S STATEMENT OF UNDERSTANDING AND CERTIFICATION

I CERTIFY that :

- I have read, understand, and agree to part IX, chapter 329, Hawaii Revised Statutes (HRS): Medical Use of
- I have a debilitating medical condition(s), as defined therein, and as stated in section C of this application;
- My use of is solely for the treatment of the specified debilitating medical condition;
- 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 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

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

Print Caregivers Name	Caregiver's Signature	Date

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.

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