

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.

	mplete or inconsistent it will be returned.			
329 Change Form Packet				
	oplicant/Patient Can Request Changes			
Section 329				
This REQUEST is for the 329 Registration Car 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 ap	pears 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 5. Add or Update Caregiver's Contact Information 3. Name and/or Date of Birth Change 6. Add, Change, or Remove my Caregiver 1. Add or Update Applicant's Contact Information 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. <u>Void 329 Card</u>				
Select one of the following below: The applicant no longer has a debilitating condition The applicant is moving out of state The applicant has a firearm permit Applicant is no longer benefiting from the use of medical cannabis				
Other (please describe): *If the natient 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 Registra	tion Card (MUST be exactly as it appears on the supporting ID)			
Maria Ma	LAN			
	Last Name:			
Patient Date of Birth from:	Change Patient Date of Birth to:			
	opear on the NEW Registration Card (MUST be <i>exactly</i> as it appears his 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:			
<u> </u>				
4. Add or Update Applicant's Contact Informati	<u>ion</u>			
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 applican	it's email address.			
5. Add or Update Caregiver's Contact Informati	<u>ion</u>			
Caregiver's Name (as stated on their ID) Select and make changes to all that apply below				
Update or Add	Update or			
Residence Address to:	Add Mailing Address To:			
Update or Add Phone Number to:				
Update or Add Email Address to:				

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

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 (liste	ed below) and designate the following individual (listed			
below) as my new primary caregiver.				
Revoke my caregiver. I will not designate a new caregiver	r.			
I hereby revoke my current designation of:				
Thereby revoke my current designation of.				
First Name Middle	Name Last Name			
Caregiver Name exactly as it app	ears on the 329 Registration Card			
I would like to designate the following individual as my prim	ary caregiver for the medical use of cannabis:			
First Name Middle				
New Caregiver's name must be exactly as it appears	ars on their government issued identification card.			
Valid Photo ID Required. Complete identification informatio	n below if adding or changing your caregiver.			
Driver's License State Identificat				
State or Country of issue:	Number:			
•	ender: Male, Female,			
Date of Birth:	Transgender: Male to Female			
Date of Bitti.				
	Transgender: Female to Male			
7. Add, Change, or Remove Grow Site				
	Calcut one of the following antique halows			
Select one of the following options below:	Select one of the following options below:			
Add a grow site (no previous grow site).	Applicant/Patient will grow own medical cannabis			
Change the current grow site to a new grow site.	Primary Caregiver will grow medical cannabis for the			
	Applicant/Qualifying Patient			
Remove the current grow site on my 329 registration	☐ Neither Applicant/Qualifying Patient NOR primary			
card (no new grow site).	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, <i>OR</i> Patient's residence address, and mailing address, <i>OR</i> 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)				

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.

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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

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.

medical use of cannabis in the State of Hawaii. I under caregivers of medical cannabis patients, I may not be pro	5	0 0.
Print Caregivers Name	Caregiver's Signature	Date

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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:

- 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

By oth qua	we not intentionally furnished false or fracting signing this document I acknowledge that er applicable laws for the medical use of alified patient to use medical cannabis under Federal law.	I am subject to part IX, chapter 329, cannabis in the State of Hawaii. I u	HRS, chapter 11-160, HAR, and all understand that my registration as a		
Pri	nt Applicant (or Legal Guardian) Name	Applicant (or Legal Guardian) Signature	Date		
	REGIVER'S STATEMENT OF UNDERS regiver IF designated to grow <u>or</u> IF primary				
I, t	ne primary caregiver, CERTIFY that:				
	I understand and acknowledge that: *lect one of the following below*) I have been designated to grow medical The qualifying patient will grow on a sit	•	ifying patient, <u>OR</u>		
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 sit 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".				
into doc me	der penalty of perjury, I attest that all informentionally furnished false or fraudulent informent I acknowledge that I am subject to part I dical use of cannabis in the State of Hawaii. I ur of cannabis, I may not be protected against arrest	mation or omitted any information from X, chapter 329, HRS, chapter 11-160, HAI nderstand that even though I am following	m this application. By signing this R, and all other applicable laws for the Hawaii state laws regarding the medical		

Caregiver's Signature

Print Caregiver's Name

Date

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.

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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.