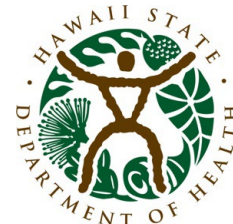


**STATE OF HAWAII**  
**DEPARTMENT OF HEALTH**  
4348 Waialae Avenue, #648  
Honolulu, Hawaii 96816



Application # \_\_\_\_\_

## 329 Grow Site Certification

**Section E.** This section **MUST** be completed and signed by the Patient and/or Primary Caregiver, if one is designated or required (either on behalf of an adult lacking legal capacity or a minor patient).

**Patient Name:**

\_\_\_\_\_  
Last First Middle Suffix

**Primary Caregiver Name:**

\_\_\_\_\_  
Last First Middle Suffix

**Select One:**

- ☐ Patient will grow own medical cannabis.  
☐ Primary Caregiver will grow medical cannabis for patient.  
☐ **Neither** the Patient nor Primary Caregiver will grow medical cannabis. (skip to page 2)

**IF the patient or caregiver is designated above to grow medical cannabis, indicate the location where the medical cannabis will be grown.**

- ☐ Patient's address (Must be owned or controlled by the Patient)  
☐ Primary caregiver's address (Must be owned or controlled by the Primary Caregiver)  
☐ Other address (Must be owned or controlled by either the patient or Primary Caregiver)

**Grow Site Address:**

\_\_\_\_\_  
Street City State Zip Code

If no street address, enter the TMK: \_\_\_\_\_  
Format: #-#-####-###-####-###

Person who owns or controls Other address property:

- ☐ Patient \_\_\_\_\_ Patient's Initials  
☐ Primary Caregiver \_\_\_\_\_ Caregiver's Initials

**STATEMENT OF UNDERSTANDING AND CERTIFICATION – ADULT or MINOR PATIENT**

**Must be completed and signed by the parent, guardian, legal custodian, or primary caregiver on behalf of an adult lacking legal capacity or minor patient.**

☐ **I, the qualifying patient, certify that:**

- 1) I plan to grow or not grow my medical cannabis, as indicated in this application.
- 2) I understand that I may only grow medical cannabis on the grow site listed in Section E.
- 3) If growing my own medical cannabis, I attest to own or control the grow site if indicated in this application.
- 4) If growing my own medical cannabis, I attest that I shall only grow cannabis at a location that is used to grow cannabis by no more than four other medical cannabis patients.
- 5) I understand I may possess, or may possess between myself and my primary caregiver, or myself and both primary caregivers (if I am a minor), an adequate supply that shall not exceed 10 cannabis plants and four ounces of usable cannabis.

**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 qualifying patient to use medical cannabis under Hawaii State law may not protect me against arrest, prosecution, or conviction under federal law.

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Signature

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Date**STATEMENT OF UNDERSTANDING AND CERTIFICATION – PRIMARY CAREGIVER(S)**

☐ **As the Primary Caregiver, I certify that:**

- 1) The total amount of medical cannabis jointly possessed between the patient and me, as the primary caregiver, or between the patient and both primary caregivers (if patient is a minor), shall not exceed 10 cannabis plants and four ounces of usable cannabis.
- 2) If I am designated to cultivate medical cannabis for the patient, I understand that cultivation is limited to the grow site listed in Section E.
- 3) I attest that I own or control the grow site listed in Section E, if so indicated in this application.
- 4) If authorized to cultivate cannabis for my registered patient(s), I agree to cultivate solely for those patient(s) and not for any other medical cannabis patient(s).
- 5) If I am designated to cultivate cannabis for the patient, I agree the cannabis plants cultivated will be individually tagged with the patient's registration number and expiration date, and used solely by the patient.
- 6) If I am designated to cultivate medical cannabis for the patient, cultivation will only occur at a location that is used to grow cannabis by no more than four other medical cannabis patients
- 7) If I am not designated to cultivate medical cannabis for the patient, I shall not cultivate cannabis for the patient.

**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 chapter 329, part IX, 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.

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Signature of Primary Caregiver for the Patient

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Date