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 _____ ❍ Primary Caregiver _____
Patient's Initials 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.

Signature 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.

Signature of Primary Caregiver for the Patient Date