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

APPLICATION #_______________________

329 Caregiver Certification

SECTION D. *This section MUST be signed by the primary caregiver, if one is designated or if one is **required** (i.e. for a minor or adult lacking legal capacity).*

Applicant's Name: ____

Last First Middle Suffix

Note: Please use your name EXACTLY as it appears on your VALID government identification

Caregiver's Name: ____

Last First Middle Suffix

CAREGIVER STATEMENT OF UNDERSTANDING AND CERTIFICATION

I CERTIFY that :

Yes No

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.

____

CAREGIVER'S SIGNATURE DATE