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

APPLICATION #_____

329 Grow Site Certification

SECTION E. *This section MUST be signed by the Applicant AND Caregiver, if designated.*

Applicant's Name: _____
Last First Middle Suffix

Caregiver's Name: _____
Last First Middle Suffix

Mark One

- ❑ Applicant/Qualifying Patient will grow own medical cannabis
- ❑ Primary Caregiver will grow medical cannabis for Applicant/Qualifying Patient
- ❑ **Neither** Applicant/Qualifying Patient **nor** Primary Caregiver will grow medical cannabis

(You Must Mark NEITHER If You Are Not Planning To Grow Medical Cannabis)

If applicant/qualifying patient or caregiver are designated above to grow, indicate the LOCATION where the medical cannabis will be grown (MUST MARK ONE of the three options below if growing):

1- ❑ Applicant/Qualifying Patient's Residence Address (as noted below) _____ Qualifying Patient Initials

OR

2- ❑ Primary Caregiver's Residence Address (as noted below) _____ Caregiver Initials

OR

3- ❑ Other Address: as noted below
(Must be owned or controlled by either the applicant or caregiver) _____ Applicant Initials _____ Primary Caregiver Initials

Person who owns or controls the "Other Address" property **MUST** initial. ***DO NOT*** *initial if* ***NOT*** *designating an "Other Address":*

Grow Site Address: _____
Street (include apt #)

_____
City State Zip Code

If no street address, please provide a COMPLETE 9 digit TMK[1] (REQUIRED) and Description:

TMK: _____

Description: _____

[1] **Use of TMK is NOT recommended.** Law Enforcement **rarely**, if ever, use the TMK to conduct a grow site verification. Only use TMK and a description for your grow site address as a last resort or if you have no other option.

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 :

❑ **Yes** ❑ **No (MUST MARK ONE)**

1. I plan to grow (or NOT grow) my medical cannabis, as indicated on the previous page and/or online.

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 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.

APPLICANT'S 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 :

❑ **Yes** ❑ **No (MUST MARK ONE)**

1. I understand and acknowledge that *(**MUST MARK ONE**)*
   ❑ 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**.

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.

PRIMARY CAREGIVER'S SIGNATURE Date