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 may be used to provide the Department of Health with written notification that would VOID a registration card for the registered patient. 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. If the program participant is deceased, this form must be signed by the physician or may be submitted by a family member with appropriate documentation (i.e. death certificate). NO FEE is required. **Incomplete Forms will be returned.**

329 Request to Void Patient's Registration Card

This Request to Void is for the 329 Registration Card #: _____

Patient Name: as it appears on the Registration Card

First Name: _____ Middle Name: _____ Last Name: _____

MARK ONE

☐ **Patient is deceased.** (If patient is deceased, physician must submit this form)

☐ **The qualifying patient no longer has a debilitating medical condition.**

☐ **The benefits of the medical use of cannabis would no longer likely outweigh the health risks for the qualifying patient.**

Physician Signature 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 form.

Print Physician Name	Physician Signature	Date

Please submit this request by US Postal Mail to:

Medical Cannabis Registry
4348 Waialae Ave, 648
Honolulu, Hawaii 96816

OR via email using the email address that is linked to your certifications