



State of Hawaii, Department of  
 Health Medical Cannabis Registry  
 Program 4348 Waialae Avenue, #648  
 Honolulu, Hawaii 96816

**Affidavit of Non-Receipt of 329 Registration Card**

**Applicant Name: as it appears on your government issued I.D.**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Please provide your mailing address below; this is where your 329 Registration Card will be mailed to. If this address is different than the mailing address provided in your initial application, it will be updated in your record.

Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

1. I submitted my application for a 329 Medical Cannabis Registration Card. I acknowledge that I have not received the 329 Registration card and I am requesting a replacement. The original 329 Registration Card mailed to me will be invalidated upon issuance of the replacement.
2. I agree to return the original invalidated 329 Registration Card if I find it and will mail it to the Department of Health, Medical Cannabis Registry Program at 4348 Waialae Avenue, #648, Honolulu, Hawaii 96816.
3. I acknowledge that this is a one-time request and that any reissuance of my 329 Registration Card hereafter will require a non-refundable fee of \$16.50 in the form of a money order or cashier’s check.
4. I have included a clear copy of my valid government issued I.D. with this affidavit.

**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 affidavit.** 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 qualified patient to use medical cannabis under Hawaii law may not protect me against arrest, prosecution, or conviction under Federal law.

\_\_\_\_\_  
 APPLICANT'S SIGNATURE

\_\_\_\_\_  
 DATE

*Please submit this affidavit and a clear copy of your valid government issued I.D. via email OR U.S. Postal Mail to:*

Medical Cannabis Registry Program  
 4348 Waialae Avenue, #648  
 Honolulu, Hawaii 96816  
 Email address: [medicalcannabis@doh.hawaii.gov](mailto:medicalcannabis@doh.hawaii.gov)