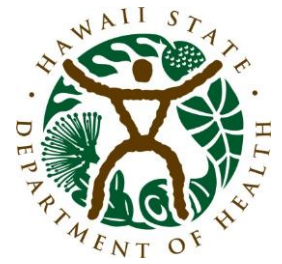




**STATE OF HAWAII**  
**DEPARTMENT OF HEALTH**  
 4348 Waiialae Avenue, #648  
 Honolulu, Hawaii 96816



## Medical Marijuana Registry Program

### Personal Verification Request

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

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

Date of Birth: \_\_\_\_\_ 329 Card OR Blue Card number: \_\_\_\_\_

1. I would like the Department of Health, Medical Marijuana Registry Program to verify that I was a registered:  
 Patient OR  Caregiver

2. Date I was registered: \_\_\_\_\_

OR enter a date range. From: \_\_\_\_\_ To: \_\_\_\_\_

3. I would also like the Department of Health, Medical Marijuana Registry Program to verify that my grow site on the date or date range stated above was:

Enter Grow Site Address: \_\_\_\_\_

4.  Please send my personal verification response to the last known email address on record, OR  
 Please send my personal verification response to the last known mailing address on record.

- *All personal verification responses will be sent to the last known email or mailing address on record.*
- *If you would like the information released to another individual or entity, please fill out the Consent to Release Information form.*
- *If your mailing address has changed, please fill out the CBD-329 The Change Form Packet.*

**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 request.** 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 marijuana in the State of Hawaii. I understand that my registration as a qualified patient to use medical marijuana under Hawaii law may not protect me against arrest, prosecution, or conviction under Federal law.

APPLICANT'S SIGNATURE (must be a handwritten signature)

DATE

Please print, complete, and submit this request via Postal mail to: 4348 Waiialae Avenue, #648, Honolulu, Hawaii 96816 OR email to [medicalmarijuana@doh.hawaii.gov](mailto:medicalmarijuana@doh.hawaii.gov). **A copy of the valid ID that you used to register MUST accompany your request.**

***Incomplete requests will be returned***