

State of Hawaii

Department of Health 4348 Waialae Avenue, #648 Honolulu, Hawaii 96816



Medical Cannabis Registry Application

All information on this form was entered electronically. For purposes of satisfying a valid request to view the electronic record, the information has been electronically transferred to this form.

Section A. Qualifying Pa	atient Info	rmation			
This is your (mark one):	O Initial App	olication -or-	• O Renewal Ap	oplication	
Note: Please use your name E	XACTLY as	it appears on yo	our VALID governn	nent-issued ident	ification.
Name:					
Last	First		Middle		Suffix
Gender (mark one): O Male	O Female	O Not specified		Date of Birt	h:
Residence Address:					
Street			City	State	Zip Code
Mailing Address: (if different from residence) Street			City	State	Zip Code
Email:					
Primary Phone:		Alt	ternate Phone:		
This is: \Box Cel	l □ Home □	Work	This	s is: Cell Hon	ne 🗖 Work
VALID GOVERNMENT-ISSU (Select one type, specify ID numb			•	v.)	—(For minors only)
Type: O Driver's Licen	se O State	Identification	O Passport	O Birth Certif	ficate
State or Country of Issue (as applicable):			
Number:				Expiration Date:	
I would like to designate a pr	rimary careg	giver:			
ONo OYes [If Yes, complete	below and pri	imary caregiver(s	s) shall complete Sect	ion D.]	
My primary caregiver for the	medical use o	of cannabis is:			
(For minors only) My primar	v caregiver #2	is.			

Patient Statement of Understanding and Certification ☐ Yes. I certify that: 1) I have read, understand, and agree to comply with chapter 329, part IX, Hawaii Revised Statutes (HRS): Medical Use of Cannabis; 2) I have been diagnosed with the medical condition(s) as certified by my medical provider and stated in this application in Section C.; 3) My use of cannabis is solely for the treatment of my certified medical condition(s) included in this application in Section C.; 4) I agree to abide by the conditions of use as provided in section 329-122, HRS, as well as ALL other sections of chapter 329, part IX, HRS. Consent to Release Information **Yes.** I consent to allow my medical provider, so named in this application, to release any protected health information pertaining to my debilitating medical condition(s) for the purpose of my registration for medical use of cannabis as set forth in chapter 329, part IX, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of my medical use of cannabis registration card or until my written revocation of this consent. I understand that if I revoke my consent, my medical use of cannabis registration card will be revoked. 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 chapter 329, part IX, HRS, chapter 11-160, Hawaii Administrative Rules (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

Patient Signature Date

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federal law.

Section	ı B.	Miı	nor or Adult Lacking Lega	l Capaci	ty Ce	ertification		
Please us	se the	patie	ent's name exactly as it appears on t	heir valid g	overni	nent-issued ide	entification or birth ce	rtificate.
Patient'	s Na	me: _						
			Last	First			Middle	Suffix
I, the pa	tient	's ca	regiver, am the (mark one):	O Parent	t C	Guardian	O Legal Custodia	n
OII	nave s	sole le	am the parent, guardian, or legal egal authority to make health care de legal authority to make health care de	ecisions on	behalf	of the patient;		
			idual with whom you share joint legal autho cable items and sign below.)	ority. Both pers	sons wit	h legal authority t	o make health care decision	ns MUST
For join	t lega	l aut	hority, both Parents, Guardians, o	or Legal Cu	ıstodia	ns, as applica	ible, must initial belo	<u>w:</u>
			The patient's primary care physicia potential risks and benefits of the r				_	the
(initial)	(ini	tial)	I consent to allow the patient to use	a madical a	onnohi	G.	-	
(initial)	(ini	tial)	I consent to serve as the primary ca					
(initial)	(ini	tial)	-	uregiver for	the pe	tront.		
			I agree to control the acquisition, d by the patient.	losage, and	freque	ncy of the med	dical use of cannabis	
(initial)	(ini	tial)	I consent to allow the patient's pri any protected health information purpose of the registration for me authorized agents of the Departme medical cannabis registration card revoke my consent, the patient's m	pertaining tedical use of the of Healt or until my	o the j f cann h. The	patient's debil abis as set for is consent is va- en revocation of	itating medical condi- th in chapter 329, par- alid for the duration of of this consent. I under	tion(s) for the t IX, HRS, to f the patient'
(initial)	(ini	tial)	-					
intentional I acknowl of cannab	ally fu ledge to is in t	rnishe that I a the Sta	rjury, I attest that all information sued false or fraudulent information or of am subject to chapter 329, part IX, HRS ate of Hawaii. I understand that the protect me or the patient against arrest,	omitted any i S, chapter 11 patient's regi	nform : l-160, l stration	ation from this a HAR, and all oth as a qualified	application. By signing her applicable laws for t patient to use medical of	this document he medical use
Print name of Parent, Guardian, or Legal Custodian who is Primary Caregiver for the patient			N	ame of		GTODY (if applicable), p Guardian, or Legal Cust Caregiver #2		
Signature of	of Paren	nt, Gua	ardian, or Legal Custodian			Date		
Signature of	of secon	nd Pare	ent, Guardian, or Legal Custodian			Date		

Section	C. Physician/APRN's W	ritten Certification	<u>n</u>		
Physician	n/APRN's Name:	E' 4		. 1 11	g cr
	Last	First	IVI	iddle	Suffix
Office Ad	Idress:		City	State	Zip Code
			•	State	Zip Code
Mailing A	Address: Street		City	State	Zip Code
Email:			·		•
				one:	
Current a	nd valid Hawaii Medical or A l	PRN License Number	::		
Current an	nd valid State Controlled Subs	stance Registration N	umber:		
CERTI	FICATION				
	CERTIFY that I have diagnosed fined in section 329-121, HRS.	the above-named patient	as having a debilitat	ing medical con	dition(s) as
	CERTIFY that I have diagnosed d I am primarily responsible for				
	CERTIFY that I am the hospice			 (8)	,.
	e Patient's Diagnosed Medical Cond	•	•		
1110	Tunent b Blagnosea Mearcar Conc				
	I CERTIFY that the patient's m chronic in nature and I recomm			eir use of medica	l cannabis is
□ Fu	irthermore, I certify that:	J			
1)	I have completed a full assessme maintain a bona fide physician-p	•	•		ion, and I
2)	It is my professional opinion that the health risks for this patient; a		f the medical use of	cannabis would l	ikely outweigh
3)	I have explained the potential ris of a patient who is a minor, to the minor.				
	alty of perjury, I attest that all info ly furnished false or fraudulent in				
document, I the medical	I acknowledge that I am subject to chuse of cannabis in the State of Hawa	napter 329, part IX, HRS, oaii. I understand that even	chapter 11-160, HAR, though I am followin	and all other appl g Hawaii State lav	icable laws for vs regarding
ceruiying n	ny patient to use medical cannabis, I	may not be protected again	nsi arrest, prosecution	, or conviction un	uci iederai iaw.
Physician	or APRN Signature				-

Section D. Prim	ary Care	giver Info	rmation (if app	licable)		
Please use your nam	e exactly a	s it appears	on your valid gove	ernment-issued idei	ntification.	
Name:						
Last			First	Middle		Suffix
Gender (mark one):	O Male	O Female	O Not specified	Date of B	Birth:	
Residence Address						
	Street			City	State	Zip Code
Mailing Address: (if different from residen				City	State	Zip Code
Email:						
Primary Phone:			Alter	nate Phone:		
Primary Phone: Th	is is: □ Cell	Home D	Work	This is	: 🗖 Cell 🗖 Home	e 🗖 Work
7 1	ecify ID nu river's Lice	mber and exnse • Sta	xpiration date, an te Identification	d attach/upload a c	lear photocopy	,
Number:					Expiration Dat	te:
 2) I agree to under application, with application of chapter 329 4) I understand the or between both four ounces of 50 or an individually ta 6) If I am designate in such application of the properties o	at: I understand rtake respon th respect to be by the Con part IX, HR te total amou h primary ca usable canna ted to cultiv gged with th tat, if I am au ocation, unle section E of cultivate ca nedical canna at, if I am au ocation that i lry, I attest to I false or fra ge that I am s abis in the St	chapter 329, p sibility for ma- the medical used ditions of Use S; and nt of adequate regivers (if the abis. ate cannabis for e patient's region athorized to cu- ss the patient in this application annabis for my abis patient(s). athorized to cu- sused to grow that all information and the complete to chapte ate of Hawaii.	art IX, HRS: Medical haging the well-being se of cannabis; as outlined in section supply possessed be expatient is a minor), or the patient, I agree stration number and litivate cannabis for me a minor with two possessed patient(s). It is a minor with two possessed be expatient and it is a minor with two possessed be expatient, I agree stration number and litivate cannabis for me cannabis by no more action submitted is to mation or omitted and are 329, part IX, HRS I understand that every	Il Use of Cannabis; g of the qualifying part of the qualifying part of 329-122, HRS, as we tween patient and prinshall not exceed: 10 certain the cannabis plants of expiration date, and only registered patient, rimary caregivers residually registered patient, at the than four other med rue to the best of my ny information from though I am following the part of the	ell as ALL other assumary caregiver, cannabis plants and ultivated will be used solely by the predical cannabis of iding in different locally for those pations are understanding an this application. Ex, and all other apping Hawaii state law	pplicable sections dentient. can only be ocations, as dent(s) and not and that I have not By signing this licable laws for we regarding
Primary Caregiver Signatu	re			Date		_

Section D. Primary Caregiver #2 I	nformation (if an	oplicable)		
Please use your name exactly as it appears	` -	· · · · · · · · · · · · · · · · · · ·	fication	
	_	intent issued tachtig	icanon.	
Name:	First	Middle		Suffix
Gender (mark one): O Male O Female		Date of	Rirth:	
,	•	Date of	Dii (ii	
Residence Address: Street		City	State	Zip Code
Mailing Address:		•	State	Zip code
(if different from residence) Street		City	State	Zip Code
Email:		Ž		1
		oto Dhomo.		
Primary Phone: This is: □ Cell □ Home □	Alterna Work	This is:	Cell □ Home	□ Work
	Work	11115 15.	- cen - mome	- WOIK
VALID GOVERNMENT-ISSUED PHO	TO IDENTIFICAT	ION REQUIRED		
(Check one type, specify ID number and e	xpiration date, and	attach/upload a clea	r photocopy))
Type: O Driver's License O Sta	te Identification Q	Passport		
• 1		•		
State or Country of Issue (as applicable):			
Number:		F	Expiration Dat	e:
STATEMENT OF UNDERSTANDING	AND CERTIFICAT	ΓΙΟΝ		
		HOIV		
☐ Yes, I certify that:				
 I have read and understand chapter 329, 1 I agree to undertake responsibility for ma application, with respect to the medical undertakened. 	inaging the well-being of		nt, so named as t	he patient on this
3) I agree to abide by the Conditions of Use of chapter 329, part IX, HRS; and		329-122, HRS, as well	as ALL other ap	oplicable sections
 I understand the total amount of adequate or between both primary caregivers (if the four ounces of usable cannabis. 				
5) If I am designated to cultivate cannabis for				.• .
individually tagged with the patient's reg 6) I understand that, if I am authorized to cu				
grown at one location, unless the patient				
designated in Section E of this applicatio	n.			
 If authorized to cultivate cannabis for my for any other medical cannabis patient(s) 		agree to cultivate sole	ly for those pation	ent(s) and not
8) I understand that, if I am authorized to cu		registered patient. I sh	nall only grow	
cannabis at a location that is used to grow	-			nts.
Under penalty of perjury, I attest that all inform				
intentionally furnished false or fraudulent infor				
document, I acknowledge that I am subject to chap the medical use of cannabis in the State of Hawaii.				
primary caregivers of medical cannabis patients, I				
Primary Caregiver #2 Signature				-

Section E. Grow Site Designation

The total amount of medical cannabis jointly possessed between patient and primary caregiver, or between patient and both primary caregivers (if the patient is a minor), shall not exceed: 10 cannabis plants and four ounces of usable cannabis.

Mark o	one:				
0	Qualifying Patient will grow own medical	cannabis.			
O	Primary Caregiver will grow medical cann	abis for the I	Patient.		
O	Primary Caregiver #2 (minors only) will g	grow medical	cannabis for the Patie	ent.	
O	Both Primary Caregivers (minors only) \boldsymbol{w}	ill grow med	lical cannabis for the I	Patient.	
O	Neither the Patient nor Primary Caregiver(s) will grow n	nedical cannabis.		
	If neither, then skip to the next page.				
IF the	e patient or caregiver(s) is/are designated a	bove to grov	v medical cannabis, i	indicate tl	he location(s)
	e the medical cannabis will be grown.	.sove to gro	· · · · · · · · · · · · · · · · · · ·		10 10 cm (s)
	Patient's Residence Address (Must be owned	on controlled	hy the Detient):		
_	1 atient's residence Address (Must be owned	or controlled	by the rationt).		
	Street		City	State	Zip Code
	Primary Caregiver Residence Address (Mus	st be owned or	controlled by the Primar	y Caregive	r):
			·		,
	Street		City	State	Zip Code
	Primary Caregiver #2 (Minors only) Resider	nce Address (Owned or controlled by	Primary Ca	aregiver #2):
			~.		
	Street		City	State	Zip Code
	•	either the Pat	ient, Primary Caregiver,	or Primary	Caregiver #2
	in the case of a minor):				
	Street		City	State	Zip Code
	If no street address, enter the TMK:			22	Zip couc
	Person who owns or controls this Other address proj	perty:			
	O Patient O Primary Caregiver		O Primary Caregiver #	#2	_
	Initials	Initials	(Minors only)	Initials	
	Other address (Must be owned or controlled by	either the Pat	ient, Primary Caregiver,	or Primary	Caregiver #2
	in the case of a minor):				
			ar.	~	7: 0.1
	Street If no street address, enter the TMK:		City	State	Zip Code
	Person who owns or controls this Other address proj	nerty:			
	O Primary Caregiver #2	porty.			
	(Minors only) Initials				

PATIENT STATEMENT OF UNDERSTANDING AND CERTIFICATION – ADULT ONLY

☐ Yes, I, the qualifying patient, certify that:

- 1) I plan to grow or not grow my medical cannabis, as indicated in this application.
- 2) I understand that I may only grow medical cannabis on the grow site listed in Section E.
- 3) If growing my own medical cannabis, I attest to own or control the grow site if indicated in this application.
- 4) If growing my own medical cannabis, I attest that I shall only grow cannabis at a location that is used to grow cannabis by no more than four other medical cannabis patients.
- 5) I understand I may possess, or may possess between myself and my primary caregiver, or myself and both primary caregivers (if I am a minor), an adequate supply that shall not exceed 10 cannabis plants and four ounces of usable

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 chapter 329, part IX, 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 qualifying patient to use medical cannabis under Hawaii State law may not protect me against arrest, prosecution, or conviction under federal law.

Signature	Date

If the patient is a minor or an adult lacking legal capacity, then the parent, guardian, or legal custodian's signature is required.

If applicable - PRIMARY CAREGIVER'S STATEMENT OF UNDERSTANDING AND CERTIFICATION ☐ As the Primary Caregiver, I certify that:

- 1) The total amount of medical cannabis jointly possessed between the patient and me, as the primary caregiver, or between the patient and both primary caregivers (if patient is a minor), shall not exceed 10 cannabis plants and four ounces of usable cannabis.
- 2) If I am designated to cultivate medical cannabis for the patient, I understand that cultivation is limited to the grow site listed in Section E.
- 3) I attest that I own or control the grow site listed in Section E, if so indicated in this application.
- 4) If authorized to cultivate cannabis for my registered patient(s), I agree to cultivate solely for those patient(s) and not for any other medical cannabis patient(s).
- 5) If I am designated to cultivate cannabis for the patient, I agree the cannabis plants cultivated will be individually tagged with the patient's registration number and expiration date, and used solely by the patient.
- 6) If I am designated to cultivate medical cannabis for the patient, cultivation will only occur at a location that is used to grow cannabis by no more than four other medical cannabis patients
- 7) If I am not designated to cultivate medical cannabis for the patient, I shall not cultivate cannabis for the patient.

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 chapter 329, part IX, 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.

Signature of Parent, Guardian, or Legal Custodian who is Primary Caregiver for the patient	Date	

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If the patient is a minor or an adult lacking legal capacity, then the parent, guardian, or legal custodian's signature is required.

If applicable - PRIMARY CAREGIVER #2 STATEMENT OF UNDERSTANDING AND CERTIFICATION (applicable only for minors)

☐ Yes, I, the Primary Caregiver #2, certify that:

- 1) The total amount of medical cannabis jointly possessed between the patient and me, as the primary caregiver, or between the patient and both primary caregivers (if patient is a minor), shall not exceed 10 cannabis plants and four ounces of usable cannabis.
- 2) If I am designated to cultivate medical cannabis for the patient, I understand that cultivation is limited to the grow site listed in Section E.
- 3) I attest that I own or control the grow site listed in Section E, if so indicated in this application.
- 4) If authorized to cultivate cannabis for my registered patient(s), I agree to cultivate solely for those patient(s) and not for any other medical cannabis patient(s).
- 5) If I am designated to cultivate cannabis for the patient, I agree the cannabis plants cultivated will be individually tagged with the patient's registration number and expiration date, and used solely by the patient.
- 6) If I am designated to cultivate medical cannabis for the patient, cultivation will only occur at a location that is used to grow cannabis by no more than four other medical cannabis patients
- 7) If I am not designated to cultivate medical cannabis for the patient, I shall not cultivate cannabis for the patient.

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 chapter 329, part IX, 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.

Signature of Parent, Guardian, or Legal Custodian who is Primary Caregiver #2	Date	
for the patient (Minors only)		

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