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 Patient Information

This is your (mark one): ❍ Initial Application -or- ❍ Renewal Application

*Note: Please use your name **EXACTLY** as it appears on your **VALID** government-issued identification.*

Name: _____
Last First Middle Suffix

Gender (mark one): ❍ Male ❍ Female ❍ Not specified **Date of Birth**: _____

Residence Address: _____
Street City State Zip Code

Mailing Address: _____
(if different from residence) Street City State Zip Code

Email: _____

Primary Phone: _____ **Alternate Phone**: _____
This is: ❑ Cell | ❑ Home | ❑ Work This is: ❑ Cell | ❑ Home | ❑ Work

VALID GOVERNMENT-ISSUED PHOTO IDENTIFICATION REQUIRED
(Select one type, specify ID number and expiration date, and attach a clear photocopy.)

(**For minors only**)

Type: ❍ Driver's License ❍ State Identification ❍ Passport ❍ Birth Certificate

State or Country of Issue (as applicable): _____

Number: _____ Expiration Date: _____

I would like to designate a primary caregiver:
❍ No ❍ Yes *[If Yes, complete below and primary caregiver(s) shall complete Section D.]*

My primary caregiver for the medical use of cannabis is: _____

(**For minors only**) My primary 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 federal law.

Patient Signature _____ Date _____

Section B. Minor or Adult Lacking Legal Capacity Certification

*Please use the patient's name **exactly** as it appears on their **valid** government-issued identification or birth certificate.*

Patient's Name: _____
Last First Middle Suffix

I, the patient's caregiver, am the (mark one): ❍ Parent ❍ Guardian ❍ Legal Custodian

❑ **I certify** that I am the parent, guardian, or legal custodian of the patient; **and**
❍ I have sole legal authority to make health care decisions on behalf of the patient; **or**
❍ I share joint legal authority to make health care decisions on behalf of the patient with:

_____
(Name of individual with whom you share joint legal authority. Both persons with legal authority to make health care decisions MUST initial the applicable items and sign below.)

For joint legal authority, both Parents, Guardians, or Legal Custodians, as applicable, must initial below:

(initial)	(initial)	The patient's primary care physician/APRN, so named in this application, has explained the potential risks and benefits of the medical use of cannabis to me and the patient.
(initial)	(initial)	I consent to allow the patient to use medical cannabis.
(initial)	(initial)	I consent to serve as the primary caregiver for the patient.
(initial)	(initial)	I agree to control the acquisition, dosage, and frequency of the medical use of cannabis by the patient.
(initial)	(initial)	I consent to allow the patient's primary care physician/APRN, so named in this application, to release any protected health information pertaining to the patient's debilitating medical condition(s) for the purpose of the 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 the patient's medical cannabis registration card or until my written revocation of this consent. I understand that if I revoke my consent, the patient's medical 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, HAR, and all other applicable laws for the medical use of cannabis in the State of Hawaii. I understand that the patient's registration as a qualified patient to use medical cannabis under Hawaii law may not protect me or the patient against arrest, prosecution, or conviction under federal law.

_____
Print name of Parent, Guardian, or Legal Custodian who is **Primary Caregiver** for the patient

_____
For JOINT LEGAL CUSTODY (if applicable), print Name of **second** Parent, Guardian, or Legal Custodian who may act as Primary Caregiver #2

_____ _____
Signature of Parent, Guardian, or Legal Custodian Date

_____ _____
Signature of second Parent, Guardian, or Legal Custodian Date

Section C. Physician/APRN's Written Certification

Physician/APRN's Name: _____
Last First Middle Suffix

Office Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Email: _____ **Office Phone**: _____

Current and valid **Hawaii Medical or APRN License Number**: _____

Current and valid **State Controlled Substance Registration Number**: _____

CERTIFICATION

- ❑ **I CERTIFY** that **I have diagnosed** the above-named patient as having a debilitating medical condition(s) as defined in section 329-121, HRS.
- ❑ **I CERTIFY** that **I have diagnosed** the above-named patient as having the medical condition(s) recorded below and **I am primarily responsible for the ongoing care and treatment** of the medical condition(s).
- ❑ **I CERTIFY** that **I am the hospice provider** for the above-named patient.

The Patient's Diagnosed Medical Condition(s):

- ❑ **I CERTIFY** that the patient's medical condition for which I am certifying their use of medical cannabis is **chronic in nature** and I recommend a 2-year certification.

- ❑ **Furthermore, I certify that:**
  1) I have completed a full assessment of the patient's medical history and current medical condition, and I maintain a bona fide physician-patient or APRN-patient relationship with the patient; and
  2) It is my professional opinion that the potential benefits of the medical use of cannabis would likely outweigh the health risks for this patient; and
  3) I have explained the potential risks and benefits of the medical use of cannabis to this patient and, in the case of a patient who is a minor, to the minor's parent(s), guardian(s), or person(s) having legal custody of the minor.

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 certifying my patient to use medical cannabis, I may not be protected against arrest, prosecution, or conviction under federal law.

_____ _____
Physician or APRN Signature Date

Section D. Primary Caregiver Information (if applicable)

*Please use your name **exactly** as it appears on your **valid** government-issued identification.*

Name: _____
Last First Middle Suffix

Gender (mark one): ❍ Male ❍ Female ❍ Not specified **Date of Birth**: _____

Residence Address: _____
Street City State Zip Code

Mailing Address: _____
(if different from residence) Street City State Zip Code

Email: _____

Primary Phone: _____ **Alternate Phone**: _____
This is: ❑ Cell | ❑ Home | ❑ Work This is: ❑ Cell | ❑ Home | ❑ Work

VALID GOVERNMENT-ISSUED PHOTO IDENTIFICATION REQUIRED

(Check **one** type, specify ID **number** and **expiration** date, **and** attach/upload a **clear photocopy**)

Type: ❍ Driver's License ❍ State Identification ❍ Passport

State or Country of Issue (as applicable): _____

Number: _____ Expiration Date: _____

STATEMENT OF UNDERSTANDING AND CERTIFICATION

❑ **Yes, I certify** that:

1) I have read and understand chapter 329, part IX, HRS: Medical Use of Cannabis;
2) I agree to undertake responsibility for managing the well-being of the qualifying patient, so named as the patient on this application, with respect to the medical use of cannabis;
3) I agree to abide by the Conditions of Use as outlined in section 329-122, HRS, as well as ALL other applicable sections of chapter 329, part IX, HRS; and
4) I understand the total amount of adequate supply possessed between patient and primary caregiver, or between both primary caregivers (if the patient is a minor), shall not exceed: 10 cannabis plants and four ounces of usable cannabis.
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) I understand that, if I am authorized to cultivate cannabis for my registered patient, medical cannabis can only be grown at one location, unless the patient is a minor with two primary caregivers residing in different locations, as designated in Section E of this application.
7) 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).
8) I understand that, if I am authorized to cultivate cannabis for my registered patient, I shall only grow cannabis at a location that is used to grow cannabis by no more than four other medical cannabis patients.

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.

_____ _____
Primary Caregiver Signature Date

Section D. Primary Caregiver #2 Information (if applicable)

*Please use your name **exactly** as it appears on your **valid** government-issued identification.*

Name: _____
Last First Middle Suffix

Gender (mark one): ❍ Male ❍ Female ❍ Not specified **Date of Birth**: _____

Residence Address: _____
Street City State Zip Code

Mailing Address: _____
(if different from residence) Street City State Zip Code

Email: _____

Primary Phone: _____ **Alternate Phone**: _____
This is: ❑ Cell | ❑ Home | ❑ Work This is: ❑ Cell | ❑ Home | ❑ Work

VALID GOVERNMENT-ISSUED PHOTO IDENTIFICATION REQUIRED

(Check **one** type, specify ID **number** and **expiration** date, **and** attach/upload a **clear photocopy**)

Type: ❍ Driver's License ❍ State Identification ❍ Passport

State or Country of Issue (as applicable): _____

Number: _____ Expiration Date: _____

STATEMENT OF UNDERSTANDING AND CERTIFICATION

❑ Yes, I certify that:

1) I have read and understand chapter 329, part IX, HRS: Medical Use of Cannabis;
2) I agree to undertake responsibility for managing the well-being of the qualifying patient, so named as the patient on this application, with respect to the medical use of cannabis;
3) I agree to abide by the Conditions of Use as outlined in section 329-122, HRS, as well as ALL other applicable sections of chapter 329, part IX, HRS; and
4) I understand the total amount of adequate supply possessed between patient and primary caregiver, or between both primary caregivers (if the patient is a minor), shall not exceed: 10 cannabis plants and four ounces of usable cannabis.
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) I understand that, if I am authorized to cultivate cannabis for my registered patient, medical cannabis can only be grown at one location, unless the patient is a minor with two primary caregivers residing in different locations, as designated in Section E of this application.
7) 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).
8) I understand that, if I am authorized to cultivate cannabis for my registered patient, I shall only grow cannabis at a location that is used to grow cannabis by no more than four other medical cannabis patients.

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.

_____ _____
Primary Caregiver #2 Signature Date

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 one:

- ❍ **Qualifying Patient** will grow own medical cannabis.
- ❍ **Primary Caregiver** will grow medical cannabis for the Patient.
- ❍ **Primary Caregiver #2** (**minors only**) will grow medical cannabis for the Patient.
- ❍ **Both Primary Caregivers** (**minors only**) will grow medical cannabis for the Patient.
- ❍ **Neither** the Patient nor Primary Caregiver(s) will grow medical cannabis.
  If neither, then skip to the next page.

IF the patient or caregiver(s) is/are designated above to grow medical cannabis, indicate the location(s) where the medical cannabis will be grown.

- ❑ Patient's Residence Address (**Must be owned or controlled by the Patient**):

  _____
  Street City State Zip Code

- ❑ Primary Caregiver Residence Address (**Must be owned or controlled by the Primary Caregiver**):

  _____
  Street City State Zip Code

- ❑ Primary Caregiver #2 (Minors only) Residence Address (**Owned or controlled by Primary Caregiver #2**):

  _____
  Street City State Zip Code

- ❑ Other address (**Must be owned or controlled by either the Patient, Primary Caregiver, or Primary Caregiver #2 in the case of a minor**):

  _____
  Street City State Zip Code

  If no street address, enter the TMK: _____

  Person who owns or controls this Other address property:

  ❍ Patient _____ Initials ❍ Primary Caregiver _____ Initials ❍ Primary Caregiver #2 (**Minors only**) _____ Initials

- ❑ Other address (**Must be owned or controlled by either the Patient, Primary Caregiver, or Primary Caregiver #2 in the case of a minor**):

  _____
  Street City State Zip Code

  If no street address, enter the TMK: _____

  Person who owns or controls this Other address property:

  ❍ Primary Caregiver #2 (**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 cannabis.

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 _____

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 for the patient **(Minors only)**	Date