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

Application # _____

329 Caregiver Certification

SECTION D. This section MUST be completed and signed by the primary caregiver, if one is designated or if one is required (i.e., for an adult lacking legal capacity or a minor).

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

Patient Name:

Last	First	Middle	Suffix

Primary Caregiver Name:

Last	First	Middle	Suffix

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 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 rules adopted thereunder; 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 _____