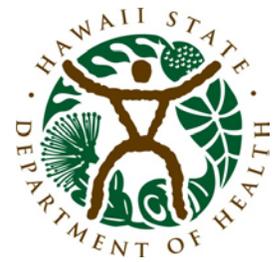




**STATE OF HAWAII**  
**DEPARTMENT OF HEALTH**  
 4348 Waiālae Avenue, #648  
 Honolulu, Hawaii 96816



## Medical Marijuana Registry Program

In accordance with Hawaii Revised Statutes 329-123 (b) "Qualifying patients shall report changes in information within ten working days." This form must be signed by the registered patient or by the appropriate parent, guardian, or legal custodian, as applicable, if the registered patient is a minor or adult lacking legal capacity. It is your responsibility to notify your certifying physician of any changes to your information.

**If the packet is incomplete or inconsistent it will be returned.**

### 329 Change Form Packet Only the Registered Applicant/Patient Can Request Changes

#### Section 329

This REQUEST is for the 329 Registration Card #:  
 OR 6 digit Application #: \_\_\_\_\_

**Applicant Name: as it appears on my current 329 Registration Card**

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

**Current Caregiver Name (if applicable): as it appears on my current 329 Registration Card**

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

**THIS IS A REQUEST TO (select ALL that apply and fill out all corresponding sections:**

- |   |   |
|---|---|
| <input type="checkbox"/> 1. Request a Replacement 329 Card (lost, stolen, or damaged) | <input type="checkbox"/> 5. Add or Update Caregiver's Contact Information |
| <input type="checkbox"/> 2. Void 329 Card   | <input type="checkbox"/> 6. Add, Change, or Remove my Caregiver           |
| <input type="checkbox"/> 3. Name and/or Date of Birth Change                          | <input type="checkbox"/> 7. Add, Change, or Remove Grow Site              |
| <input type="checkbox"/> 4. Add or Update Applicant's Contact Information             |   |

#### 1. Request a Replacement 329 Card

Yes  No: My card has been lost, stolen, or damaged. Please reissue my 329 card.

#### 2. Void 329 Card

Select one of the following below:

- |  |  |
|--|--|
| <input type="checkbox"/> The applicant no longer has a debilitating condition                | <input type="checkbox"/> The applicant is moving out of state                |
| <input type="checkbox"/> The applicant has a firearm permit                                  | <input type="checkbox"/> The applicant will be applying for a firearm permit |
| <input type="checkbox"/> Applicant is no longer benefiting from the use of medical marijuana |  |
| <input type="checkbox"/> Other (please describe): _____                                      |  |

\*If the patient is deceased, the certifying physician must fill out a separate form: "Void Request by Physician"

# Medical Marijuana Registry Program

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## 3. Name and/or Date of Birth Change

**Patient Name as it will appear on the NEW Registration Card** (MUST be *exactly* as it appears on the supporting ID)

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

Patient Date of Birth from: \_\_\_\_\_ Change Patient Date of Birth to: \_\_\_\_\_

**Current Caregiver Name (if applicable): as it will appear on the NEW Registration Card** (MUST be *exactly* as it appears on the supporting ID) editing your caregivers name in this section does not mean you are adding or changing your caregiver.

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

Caregiver Date of Birth from: \_\_\_\_\_ Change Caregiver Date of Birth to: \_\_\_\_\_

## 4. Add or Update Applicant's Contact Information

Select and make changes to all that apply below

Update Residence Address \_\_\_\_\_  Update Mailing Address To: \_\_\_\_\_  
to: \_\_\_\_\_

Update Phone Number to: \_\_\_\_\_  
 Update Email Address to: \_\_\_\_\_

## 5. Add or Update Caregiver's Contact Information

Caregiver's Name (as stated on their ID) \_\_\_\_\_

Select and make changes to all that apply below

Update or Add Residence Address \_\_\_\_\_  Update or Add Mailing Address To: \_\_\_\_\_  
to: \_\_\_\_\_

Update or Add Phone Number to: \_\_\_\_\_

Update or Add Email Address to: \_\_\_\_\_



# Medical Marijuana Registry Program

In accordance with Hawaii Revised Statutes 329-123 (b) "Qualifying patients shall report changes in information within ten working days." This form must be signed by the registered patient or by the appropriate parent, guardian, or legal custodian, as applicable, if the registered patient is a minor or adult lacking legal capacity. It is your responsibility to notify your certifying physician of any changes to your information.

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## 329A. APPLICANT'S STATEMENT OF UNDERSTANDING AND CERTIFICATION

### I CERTIFY that :

- 1) I have read, understand, and agree to part IX, chapter 329, Hawaii Revised Statutes (HRS): Medical Use of Marijuana;
- 2) I have a debilitating medical condition(s), as defined therein, and as stated in section C of this application;
- 3) My use of marijuana is solely for the treatment of the specified debilitating medical condition;
- 4) I agree to abide by the Conditions of Use as outlined in part IX, section 329-122, HRS, as well as ALL other applicable sections of 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.

**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 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.

Print Applicant (or Legal Guardian) Name

Applicant (or Legal Guardian) Signature

Date

## 6A. NEW 329 CAREGIVER'S STATEMENT OF UNDERSTANDING AND CERTIFICATION

### I CERTIFY that :

- 1) I have read and understand part IX, chapter 329, HRS: Medical Use of Marijuana;
- 2) I agree to undertake responsibility for managing the well-being of the qualifying patient, so named as the applicant on this application, with respect to the medical use of marijuana;
- 3) I agree to abide by the Conditions of Use as outlined in part IX, section 329-122, HRS, as well as ALL other applicable sections of 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; and
- 4) I understand that in accordance with part IX, chapter 329, HRS, medical marijuana can only be grown at one location, as designated in Section E of this application.

**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 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 even though I am following Hawaii state laws regarding primary caregivers of medical marijuana patients, I may not be protected against arrest, prosecution, or conviction under Federal law.

Print Caregivers Name

Caregiver's Signature

Date

# Medical Marijuana Registry Program

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## 7A. GROW SITE CERTIFICATION

**APPLICANT'S STATEMENT OF UNDERSTANDING AND CERTIFICATION** (*This section **MUST** be signed by applicant, regardless of intent to grow. If applicant is a minor or adult lacking legal capacity, this section **MUST** be signed by the parent, guardian or legal custodian, as applicable*)

I, the **applicant**/qualifying patient, CERTIFY that :

1. I plan to grow (or NOT grow) my medical marijuana, as indicated on the previous page.
2. If I've indicated a grow site location other than my residence (an "Other Address") AND I've indicated that I either own or control the "Other Address", as evidenced by my initials where applicable, I attest **that I either own or control the stated grow site location.**

**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 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.

Print Applicant (or Legal Guardian) Name

Applicant (or Legal Guardian)  
Signature

Date

**CAREGIVER'S STATEMENT OF UNDERSTANDING AND CERTIFICATION** (***MUST** be signed by primary caregiver IF designated to grow or IF primary caregiver either owns or controls the grow site location*)

I, the primary **caregiver**, CERTIFY that :

1. I understand and acknowledge that:

(*Select one of the following below*)

- I have been designated to grow medical marijuana by the aforementioned qualifying patient, OR
- The qualifying patient will grow on a site that I own or control; AND

2. If I've indicated a grow site location other than my residence AND I've indicated that I either own or control the "Other Address", as evidenced by my initials above, I **ATTEST that I either own or control the stated grow site location.**
3. If I've indicated a grow site location that I own or control, I am responsible for ensuring that the grow site location remains compliant with part IX, chapter 329, HRS, specifically any limitations to "adequate supply".

**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 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 even though I am following Hawaii state laws regarding the medical use of marijuana, I may not be protected against arrest, prosecution, or conviction under Federal law.

Print Caregiver's Name

Caregiver's Signature

Date