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

APPLICATION #_____

Medical Use of Marijuana Applicant Certification

SECTION A. *This section to be signed by the applicant/qualifying patient OR if applicant is a minor, by the parent, guardian or legal custodian*

Applicant's Name: _____
Last First Middle

Note: Use your name EXACTLY as it appears on your VALID government identification (or Birth Certificate if minor applicant w/o ID)

My primary care physician for the medical use of marijuana is: _____

I would like to designate a primary caregiver: □ Yes □ No *(If "yes", primary caregiver shall complete Section D)*

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

APPLICANT STATEMENT OF UNDERSTANDING AND CERTIFICATION

I CERTIFY that :

□ **Yes** □ **No**

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.

CONSENT TO RELEASE INFORMATION

□ **Yes** □ **No**

I consent to allow my primary care physician, so named in this application, to release any protected health information pertaining to my debilitating medical condition for the purpose of my registration for medical use of marijuana as set forth in part IX, chapter 329, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of my medical use of marijuana registration card or upon my written revocation of this consent. I understand that if I revoke my consent, my medical use of marijuana 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 part IX, chapter 329, HRS, 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 DATE

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

APPLICATION #_____

Medical Use of Marijuana Minor Certification

SECTION B. *This section to be signed by the parent, guardian or legal custodian of a minor applicant.*

Minor Applicant's NAME:

_____
Last First Middle

Note: Please use the minor's name EXACTLY as it appears on their VALID government identification or Birth Certificate.

I am the: □ **Parent** **OR** □ **Guardian** **OR** □ **Legal Custodian** *(mark one)*

I CERTIFY that:

□ Yes □ No I am the parent, guardian, or legal custodian of the above mentioned minor qualifying patient; and

□ Yes □ No I have legal authority to make health care decisions on behalf of the minor qualifying patient; or

□ Yes[1] □ No I share joint legal authority to make health care decisions on behalf of the minor qualifying patient with _____
(name of individual with whom you share joint legal authority)

For Joint Legal Authority, both must initial below:

(initial)	*(initial)*	The minor's primary care physician, so named on this application, has explained the potential risks and benefits of the medical use of marijuana to me and the minor qualifying patient.
(initial)	*(initial)*	I consent to allow the minor qualifying patient to use medical marijuana.
(initial)	*(initial)*	I consent to serve as the primary caregiver for the minor patient/applicant.
(initial)	*(initial)*	I agree to control the acquisition, possession, dosage, and frequency of the medical use of marijuana by the minor patient/applicant.
(initial)	*(initial)*	I consent to allow the minor qualifying patient's primary care physician, so named in this application, to release any protected health information pertaining to the minor qualifying patient's debilitating medical condition for the purpose of the registration for medical use of marijuana as set forth in part IX, chapter 329, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of the minor qualifying patient's medical use of marijuana registration card or upon my written revocation of this consent. I understand that if I revoke my consent, the minor qualifying patient's medical use of marijuana 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 part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that the minor qualifying patient's registration as a qualified patient to use medical marijuana under Hawaii law may not protect me or the minor qualifying patient against arrest, prosecution, or conviction under Federal law.

Print Name of Parent, Guardian, or Legal Custodian that will act as CAREGIVER for the Minor Applicant	For *JOINT LEGAL CUSTODY* Print *second* Parent, Guardian, or Legal Custodian's Name
Signature of Parent, Guardian, or Legal Custodian DATE	Signature of *second* Parent, Guardian, or Legal Custodian DATE

[1] *If this box is checked, both persons with legal authority to make health care decisions MUST initial the applicable items and sign this section.*

STATE OF HAWAII
DEPARTMENT OF HEALTH
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APPLICATION #_____

Medical Use of Marijuana Physician Certification

SECTION C. *This section to be signed by the certifying physician.*

Applicant's Name: _____
Last First Middle

Physician's Name: _____
Last First Middle

PHYSICIAN'S WRITTEN CERTIFICATION

□ **Yes** □ **No** I CERTIFY that in my professional opinion, my patient, so named above as the Applicant, has a debilitating medical condition as listed below or is suffering from the treatment of these conditions *(mark all that apply)*:

□ Cancer
□ Glaucoma
□ Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)
□ A chronic or debilitating disease or condition that produces one or more of the following:
- □ a. Cachexia or wasting syndrome
- □ b. Severe pain
- □ c. Severe nausea
- □ d. Seizures, including those characteristic of epilepsy
- □ e. Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease

□ **Yes** □ **No** Furthermore, I certify that:
1) I maintain a bona fide physician-patient relationship with the Applicant; and
2) It is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient; and
3) I have explained the potential risks and benefits of the medical use of marijuana 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 part IX, chapter 329, HRS, 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 certifying my patient to use medical marijuana, I may not be protected against arrest, prosecution, or conviction under Federal law.

PHYSICIAN'S SIGNATURE DATE

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

APPLICATION #_____

Medical Use of Marijuana Caregiver Certification

SECTION D. *This section to be signed by the primary caregiver, if one is designated*

Applicant's Name: _____
Last First Middle

Caregiver's Name: _____
Last First Middle

Note: Please use your name EXACTLY as it appears on your VALID government identification

CAREGIVER 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;

□ **Yes** □ **No**

3) I agree to abide by the Conditions of Use as outlined in part IX, chapter 329, HRS, as well as ALL other applicable sections of this law; 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, 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.

_____
CAREGIVER'S SIGNATURE DATE

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

APPLICATION #_____

Medical Use of Marijuana Grow Site Certification

SECTION E. *This section to be signed by the Applicant AND Caregiver, if designated.*

Applicant's Name: _____
Last First Middle

Caregiver's Name: _____
Last First Middle

Mark One

□ Applicant/Qualifying Patient will grow own medical marijuana
□ Primary Caregiver will grow medical marijuana for Applicant/Qualifying Patient
□ Neither Applicant/Qualifying Patient nor Primary Caregiver will grow medical marijuana
(YOU MUST MARK THIS IF YOU ARE NOT PLANNING TO GROW MEDICAL MARIJUANA)

If applicant/qualifying patient or caregiver are designated above to grow, indicate the LOCATION where the medical marijuana will be grown:

□ Applicant/Qualifying Patient's Residence Address (as noted on this application) _____ Qualifying Patient Initials
□ Primary Caregiver's Residence Address (as noted on this application) _____ Caregiver Initials
□ Other Address as follows: (must be owned or controlled by either the applicant or caregiver)

_____ HI _____
Street (include apt#) City State Zip Code

If no street address, TMK (and Description, REQUIRED): _____

Person who owns or controls the "Other Address" property: □ Applicant _____ initials □ Primary Caregiver _____ initials

Form CBD-001gsc
Revised 11/24/14

APPLICANT'S STATEMENT OF UNDERSTANDING AND CERTIFICATION
(must be signed by applicant/qualifying patient, regardless of intent to grow)

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

□ **Yes** 1. I plan to grow (or NOT grow) my medical marijuana, as indicated above.

□ **No** 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**.

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, 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.

APPLICANT'S 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 *(MARK ONE)*
   □ I have been designated to grow medical marijuana by the aforementioned qualifying patient, OR

□ **Yes** □ The qualifying patient will grow on a site that I own or control; AND

□ **No** **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**.

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, 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.

PRIMARY CAREGIVER'S SIGNATURE Date