STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

☐ Initial

☐ Renewal

For State NED use only:
Reg:
Exp:
Rec:

NARCOTICS ENFORCEMENT DIVISION
3375 Koapaka Street, Suite D100
Honolulu, HI 96819
Phone (808) 837-8470
Fax (808) 837-8474

WRITTEN CERTIFICATION/REGISTRY IDENTIFICATION FORMS FOR THE MEDICAL USE OF MARIJUANA

Instructions: Complete all required information in order to comply with the registration requirements of the Hawaii Medical Marijuana Act. Attach copies of required identification. If an applicant is a minor, Section B (page 2) must be completed.

A. APPLICANT INFORMATION

NAME (Last, First, M.I.):

DATE OF BIRTH: PATIENT ID NO. (Driver's License, State ID, Passport No. or SSN)

PHYSICAL ADDRESS: TELEPHONE NUMBER

CITY, STATE AND ZIP CODE:

MAILING ADDRESS (if different from physical address):

Photo Identification: A photocopy of one of the following is attached: Please check appropriate box.

☐ Hawaii Driver's License ☐ Hawaii State Identification ☐ Passport

I understand that the marijuana authorized for medical use that I may jointly possess with my primary caregiver shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant. _____ (Initials)

I understand that the medical marijuana shall be grown only at the following locations: (1) my home address; (2) my primary caregiver's home address; (3) or a location owned or leased by myself or my primary caregiver that is approved by the administrator and designated on the registry certificate issued by the department. _____ (Initials)

I understand that this certification shall not apply to:
- (1) The medical use of marijuana that endangers the health or well being of another person;
- (2) The medical use of marijuana:
  - (A) In a school bus, public bus, or any moving vehicle;
  - (B) In the workplace of one's employment;
  - (C) On any school grounds;
  - (D) At any public park, public beach, public recreation center, recreation or youth center; or
  - (E) Any other place generally accessible to the public.

(3) Any sale of marijuana; or
(4) The use of marijuana by a qualifying patient, parent, or primary caregiver for purposes other than medical use permitted by this chapter. _____ (Initials)

NOTE: The registry identification certificate authorizes the possession and use of marijuana for medical purposes under State law only. Federal law prohibits the possession, transportation, use or distribution of marijuana within the State and to locations outside the State. _____ (initials)

I certify that the information provided above is true and I consent to allow my physician or my primary caregiver, if any, to release any protected health information pertaining to my "debilitating condition" for the purpose of registration and implementation of my use of marijuana for medical purposes as set forth in Chapter 329, Part IX HRS to authorized agents of the Narcotics Enforcement Division. This consent is valid for the duration of the patient's registry identification certificate or upon my revocation. Verification of the data on this application will be conducted on all applicants as designated by Chapter 329-123, Hawaii Revised Statutes. Any person who knowingly or intentionally furnishes false or fraudulent material information or omits any material information from any application, report, or other documents that is required to be kept or filed under this chapter, shall be in violation of Chapter 710-1063, Hawaii Revised Statutes.

APPLICANT'S SIGNATURE DATE

B. AUTHORIZATION FOR MINOR APPLICANT

If the applicant is a minor (under the age of 18), please fill out this section:

I certify that I am the parent or legal guardian of the above named patient. The minor's physician has explained to me the potential risks and benefits of medical use of marijuana and I consent to serve as the primary caregiver for this patient and to control the acquisition, possession, dosage, and frequency of use of marijuana by the minor applicant.

Type or Print Parent or Legal Guardian's Name Signature of Parent or Legal Guardian

NOTE: The parent or legal guardian must also register as the applicant's primary caregiver.

C. PHYSICIAN'S WRITTEN CERTIFICATION

PHYSICIAN'S NAME (Please Print) ______________________ TELEPHONE NUMBER ______________

BUSINESS ADDRESS ______________ CITY ______________ STATE ______ ZIP CODE ______

HAWAII MEDICAL LICENSE NUMBER ______________ STATE CONTROLLED SUBSTANCE REGISTRATION NUMBER ______________

PATIENT'S NAME ______________________ DATE OF LAST VISIT ______________

I certify that my patient has been diagnosed with a debilitating medical condition as listed below and that in my professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risk of the qualifying patient.

- ☐ 1. Malignant Neoplasm (Cancer)
- ☐ 2. Glaucoma
- ☐ 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)
- ☐ 4. A chronic or debilitating disease or medical condition or its treatment that produces, for a specific patient, one or more of the following:
  - ☐ a. Cachexia / wasting syndrome
  - ☐ b. Severe pain
  - ☐ c. Severe nausea
  - ☐ d. Seizures, including but not limited to seizures caused by epilepsy
  - ☐ e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis or Crohn's disease

Comments: ____

____

____

I understand that the administering, prescribing, dispensing or facilitating the acquisition of marijuana for my patients are a violation of State law. _____ (Initials)

NOTE: This information will be kept confidential and shall not be disseminated during inquiries by Law Enforcement personnel.

I hereby certify that I am a duly licensed physician to practice medicine in Hawaii under HRS Chapter 453 and 460 (excludes physician assistants as described in Section 453-5.3). I also certify that I am registered to handle controlled substances under HRS Chapter 329-32. I have treated and the above named patient and have explained the potential risks and benefits of the medical use of marijuana to this patient. Based on my professional opinion and having completed a full assessment of my patient's medical history and current medical condition in the course of a bona fide physician-patient relationship have issued this written certification. If this patient is under the age of eighteen years, I certify that I have explained the potential risks and benefits of the medical use of marijuana to this patient and to the parent, guardian, or person having legal custody of this patient. Further, I certify that this applicant was seen and examined by me.

Verification of the data on this application will be conducted on all applicants as designated by Chapter 329-123, Hawaii Revised Statutes. Any person who knowingly or intentionally furnishes false or fraudulent material information in or omits any material information from any application, report, or other document required to be kept or filed under this chapter, shall be in violation of Chapter 710-1063, Hawaii Revised Statutes.

PHYSICIAN'S SIGNATURE ______________________ DATE ______________

D. PRIMARY CAREGIVER (If Applicable)

NAME (Last, First, M.I.): SOCIAL SECURITY NUMBER: DATE OF BIRTH

PHYSICAL ADDRESS: TELEPHONE NUMBER

CITY, STATE AND ZIP CODE:

☐ YES ☐ NO Are you at least 18 years of age?

☐ YES ☐ NO Are you presently registered with the Department as a qualified patient to utilize Marijuana for medical purposes at this time?

Photo Identification: Please check appropriate box and attach one of the following:

☐ Hawaii Driver's License ☐ Hawaii State Identification ☐ Passport

I certify that I am eighteen years of age or older and have agreed to undertake the responsibility of managing the well being of the patient mentioned above with respect to the medical use of marijuana. ____ (Initials)

I understand that the marijuana authorized for medical use that I may jointly possess with my primary caregiver shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant. _____ (Initials)

I understand that the medical marijuana shall be grown only at the following locations: (1) my home address; (2) the applicant's home address; (3) or a location owned or leased by myself or the applicant that is approved by the administrator and designated on the registry certificate issued by the department. ____ (Initials)

I understand that the medical use of marijuana in this section shall not apply to:

(1) The medical use of marijuana that endangers the health or well being of another person;
(2) The medical use of marijuana:
    (A) In a school bus, public bus, or any moving vehicle;
    (B) In the workplace of one's employment;
    (C) On any school grounds;
    (D) At any public park, public beach, public recreation center, recreation or youth center; or
    (E) Any other place generally accessible to the public.
(3) Any sale of marijuana; or
(4) The use of marijuana by a qualifying patient, parent, or primary caregiver for purposes other than medical use permitted by this chapter. _____ (Initials)

NOTE: The registry identification certificate authorizes the possession and use of marijuana for medical purposes under State law only. Federal law prohibits the possession, use or distribution of marijuana within the State of Hawaii and to locations outside of the State. _____ (Initials)

I certify that the information provided above is true and I am aware that verification of the data on this application will be conducted on all applicants as designated by Chapter 329-123, Hawaii Revised Statutes. Any person who knowingly or intentionally furnishes false or fraudulent material information or omits any material information from any application, report, or other document that is required to be kept or filed under this chapter, shall be in violation of Chapter 710-1063, Hawaii Revised Statutes.

SIGNATURE OF PRIMARY CAREGIVER DATE

E. PLANS FOR GROWING MARIJUANA

☐ Patient ☐ Primary Caregiver

NAME (Last, First, M.I.):

I plan to grow medicinal marijuana at the following location: (PHYSICAL ADDRESS OR DETAILED DESCRIPTION OF LOCATION OF GROW SITE - Location ***must*** belong to or rented by either the patient or the primary caregiver.

STREET ADDRESS OR TAX MAP KEY TELEPHONE NO.

CITY STATE ZIP CODE

I certify that the information provided above is true and I am aware that verification of the data on this application will be conducted on all applicants as designated by Chapter 329-123, Hawaii Revised Statutes. Any person who knowingly or intentionally furnishes false or fraudulent material information or omits any material information from any application, report, or other document that is required to be kept or filed under this chapter, shall be in violation of Chapter 710-1063, Hawaii Revised Statutes.

SIGNATURE OF GROWER (Patient or Primary Caregiver) DATE