GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

WRITTEN DESIGNATION FOR CAREGIVER

*Only one (1) person can be designated as Primary/Designated Caregiver for each Qualified Patient

QUALIFIED PATIENT INFORMATION

Full Name _____ Date of Birth_____

Guam Home Address_____Email Address_____

Guam Mailing Address_____Phone No_____

CAREGIVER INFORMATION

Full Name _____ Date of Birth_____

Guam Home Address_____Email Address_____

Guam Mailing Address_____Phone No_____

DECLARATION OF STATEMENT

I certify that I have designated the person named above as my primary/designated caregiver. The caregiver has agreed to assist me in the use and/or cultivation of medical cannabis in accordance with the provisions in P.L. 33-220, P.L. 34-80 and P.L. 34-125. The caregiver is at least twenty-one (21) years of age.

Qualified Patient's Signature_____ Date_____

Caregiver's Signature_____ Date_____