



**GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
CAREGIVER REGISTRATION**

This registration is only valid for one (1) year from date of issue. A copy of the qualified patient's valid written certification must be submitted with this registration.

CAREGIVER'S INFORMATION

Full Name _____ Date of Birth _____

Guam Home Address _____ Email Address _____

Guam Mailing Address _____ Phone No _____

QUALIFIED PATIENT'S INFORMATION

Full Name _____ Date of Birth _____

Guam Home Address _____ Email Address _____

Guam Mailing Address _____ Phone No _____

DECLARATION OF STATEMENT

“I certify that I am at least twenty-one (21) years of age. I have agreed to assist the qualified patient in the medical use of cannabis in accordance with the provisions in P.L. 33-220, P.L. 34-80 and P.L. 34-125. I understand that I can only be a caregiver for a maximum of up to five (5) qualified patients. Violation of this provision is punishable by a civil fine of five thousand dollars (\$5,000). I know that I am prohibited from consuming cannabis obtained for the personal, medical use of the qualified patients.”

Caregiver's Signature _____

Date _____