



**GOVERNMENT OF GUAM**  
**DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES**  
**PATIENT HOME CULTIVATION PERMIT APPLICATION**

STATUS:  New  Renewal  Copy

<b>PATIENT INFORMATION</b>		
Name	Date of Birth	Phone Number
Mailing Address	Guam Residence Address	
Physical address and location of proposed cultivation and/or storage sites	Name of owner of property where marijuana will be cultivated/or stored	

<b>PRACTITIONER INFORMATION</b>	<b>PRIMARY CAREGIVER INFORMATION</b>
Name	Name
Phone Number	Date of Birth
Address	Mailing Address
Written Certification Submitted <input type="checkbox"/> YES <input type="checkbox"/> NO	Guam Residence Address

**“I pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to P.L. 34-125.”**

\_\_\_\_\_  
**Qualified Patient’s Signature**

\_\_\_\_\_  
**Date**

*For Official Use:*

*Permit #* \_\_\_\_\_ *Date issued* \_\_\_\_\_ *Expiration Date* \_\_\_\_\_ *Registered* \_\_\_\_\_

*Authorization for use of cultivation site* \_\_\_\_\_ *storage site:* \_\_\_\_\_ *Official’s Initials/Date* \_\_\_\_\_