

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
QUALIFIED PATIENT REGISTRATION (No Registry ID Card)

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.

QUALIFIED PATIENT'S INFORMATION

Full Name _____ Date of Birth _____

Guam Home Address _____ Email Address _____

Guam Mailing Address _____ Telephone No _____

PRIMARY CAREGIVER'S INFORMATION (IF ANY)

Full Name _____ Date of Birth _____

Guam Home Address _____ Email Address _____

Guam Mailing Address _____ Telephone No _____

DECLARATION OF STATEMENT

"I attest that the information provided is true and correct. I understand I must report changes of any information on this application within ten (10) business days of the change to the Department of Public Health and Social Services (DPHSS).

Qualified Patient's Signature _____ Date _____