

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 \_\_\_\_\_