

GOVERNMENT OF GUAM  
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES  
**WRITTEN DESIGNATION FOR PRIMARY CAREGIVER**

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

**QUALIFIED PATIENT INFORMATION**

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Guam Home Address \_\_\_\_\_ Email Address \_\_\_\_\_

Guam Mailing Address \_\_\_\_\_ Telephone No \_\_\_\_\_

**PRIMARY CAREGIVER INFORMATION**

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Guam Home Address \_\_\_\_\_ Email Address \_\_\_\_\_

Guam Mailing Address \_\_\_\_\_ Telephone No \_\_\_\_\_

**DECLARATION OF STATEMENT**

I certify that I have designated the person named above as my primary caregiver. He/She has agreed to assist me in the medical use of cannabis in accordance with the provisions in Public Law 33-220 and Public Law 34-80. He/she is at least twenty-one (21) years of age.

Qualified Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Caregiver's Signature \_\_\_\_\_ Date \_\_\_\_\_