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_____