GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

PATIENT HOME CULTIVATION PERMIT APPLICATION

STATUS: ☐ **New** ☐ **Renewal** ☐ **Copy**

PATIENT INFORMATION		
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**	

PRACTITIONER INFORMATION	**PRIMARY CAREGIVER INFORMATION**
Name	**Name**
Phone Number	**Date of Birth**
Address	**Mailing Address**
Written Certification Submitted ☐ **YES** ☐ **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**

If applicable

"I am at least 21 years of age and registered with DPHSS Medical Cannabis Program, I pledge not to divert cannabis to anyone who is not allowed to possess cannabis to P.L. 34-125"

_____ _____

Patient's Designated Caregiver Signature

Date

For Official Use:

Permit#_____ Date Issued_____ Expiration Date_____ Registered_____
Authorization for use of cultivation site_____storage site:_____Official's Initials/Date_____