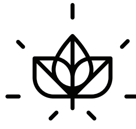


ALOHA GREEN APOTHECARY

Please fill out the portion below exactly as it appears on your 329 Hawaii medical card.

DOH Medical Cannabis Program

Registration Number: ____________________

Issued: ____________ Expires: ____________

First Name: ____________ Middle Name: ____________

Last Name: ____________

DOB: ______ / ______ / ______
MM DD YYYY

Please check here if you are an out-of-state patient with a 329V card. [ ] Aloha!

Physician: /s/ ____________________

If you are an out-of-state patient, please tell us what state you are visiting from ____________

If you are a registered caregiver, please write patient's name ____________________

Department of Health Required Contact Information

Aloha Green Apothecary keeps contact information for every patient and contacts individuals only when required (product recalls, lost personal items, etc.)

Address Line 1 ____________________

Line 2 (optional) ____________________

City ____________ Zip Code ____________

Email ____________________

Mobile Number ____________________

Loyalty Member Discount

Join our email and text lists and receive an automatic 10% off all purchases!

[ ] Yes! I want my 10% discount.

[ ] No. I do NOT want a discount.

Veteran's Honor Discount

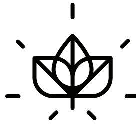
Retired military veterans and military dependents receive an automatic 20% off. Accepted documents: military-issued ID, VA-issued ID, DD214 Form.

[ ] Yes! I am eligible for 20% off.

[ ] No. I am NOT eligible.

329 Hawaii Medical Card Qualifying Condition (optional):

[ ] ALS
[ ] Cachexia
[ ] Cancer
[ ] Crohn's Disease
[ ] Epilepsy
[ ] Glaucoma
[ ] HIV/AIDS
[ ] Lupus
[ ] Multiple Sclerosis
[ ] PTSD
[ ] Rheumatoid Arthritis
[ ] Seizures
[ ] Severe Muscle Spasms
[ ] Severe Nausea
[ ] Severe Pain



ALOHA GREEN APOTHECARY

Please review the agreements provided and initial/sign below.

Do not sign the Agreement and do not use cannabis if you have questions about or do not understand the information you have received or are not comfortable assuming the risks that may be associated with cannabis use of possession.

I certify that I have read the attached Acknowledgement Disclosure and Assumption of Risk Agreement and I fully understand the potential risks and side effects related to the use of cannabis as described above. In using cannabis for medicinal use, I fully accept responsibility and assume the risks and side effects associated with its use. I further hold harmless and release Aloha Green Apothecary of any liability related to any risks.

Initial Here: ______________

I certify that I have read the attached Medical Cannabis Program Patient Agreement and declare that the information contained herein is true, correct, and complete.

Initial Here: ______________

I certify that I have read and fully understand the attached Terms and Conditions of Aloha Green Apothecary.

Initial Here: ______________

I certify that I have read, understand, and agree to the above referenced documents provided by Aloha Green Apothecary.

Signature: ______________________________ Date: ________________

Printed Name: ______________________________