STATE OF HAWAII
DEPARTMENT OF HEALTH
4348 Waialae Avenue, #648
Honolulu, Hawaii 96816

Medical Marijuana Registry

Electronic Signature Agreement

Certifying Physician's/Advance Practice Registered Nurse's (APRN) Name _____

Certifying Physician's/APRN's Valid Medical License # _____

Certifying Physician's /APRN's Valid Controlled Substance License # _____

As part of its Medical Marijuana Registry Program, the State of Hawaii, Department of Health has established an electronic data entry system for the registration of qualifying patients in the Medical Marijuana Registry. By signing this Agreement below, I agree that I explicitly understand, acknowledge, and affirm that my electronic signature on all applications and certifications that I submit electronically has the full force and effect of my handwritten signature, and that when I use my electronic signature in the Medical Marijuana Registration process I agree with all of the statements made in the application and the certification and any other documents I submit as part of the registration process as if I had signed those documents in my own handwriting. By signing below, I further agree to the following:

1. I understand that the Department of Health will keep this written Agreement and my handwritten signature on file for future reference and that it will not expire or otherwise terminate unless I submit a written request to revoke this Agreement and the Department of Health acknowledges my request in writing.
2. I authorize the Department of Health to print my name on each of my patients' Medical Marijuana Registration cards, and I agree that my printed name will serve as my electronic signature on the Medical Marijuana Registration card and will mean that I have provided the Department of Health with my electronic certification that in my professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient.
3. I understand that I am bound by all of the legal requirements of chapter 329, Hawaii Revised Statutes, and chapter 11-160, Hawaii Administrative Rules, governing the Medical Use of Marijuana.
4. I understand that if either the Department of Health or I revoke this Agreement, I will no longer be allowed to submit electronic applications in the electronic data entry system for the registration of my patients in the Medical Marijuana Registry and I may not be allowed to submit any other form of application.
5. I understand that the Department of Health may share a copy of this Agreement with law enforcement personnel, court personnel, or others for law enforcement or other appropriate purposes as determined by the Department of Health.
6. I understand that it is illegal for me to allow anyone else to have access to my electronic signature or my password that allows me to certify patients for the Medical Marijuana Registry and I agree that any use of my electronic signature means I have personally authorized its use for this purpose.

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Certifying Physician's/APRN's Signature Date