State of Vermont
Marijuana Registry
45 State Drive
Waterbury, Vermont 05671-1300

Department of Public Safety

[phone] 802-241-5115
[fax] 802-241-5230
[email] DPS.MJRegistry@vermont.gov

COMPLETE REGISTERED PATIENT APPLICATION PACKET

(Patient application, Caregiver application, and Health Care Professional Verification Form)

Instructions: Carefully review the entire application. *Legibly* complete all sections labeled **"REQUIRED"** and any applicable sections labeled **"OPTIONAL"**. Incomplete applications may be returned. Initial applications *must* be notarized and submitted with a photo of the applicant's upper body. The photo must be sent via email to DPS.MJRegistry@vermont.gov prior to submitting your application or on a CD with your application. Renewal applicants are *not required* to submit a photo or have the application notarized. All patient applications ***must*** be submitted with a $50 fee payable to the Department of Public Safety.

COMPLETE ALL SECTIONS OF THIS FORM LABELED REQUIRED

1.) CONTACT INFORMATION (REQUIRED)

☐ Initial Application ☐ Renewal Application (ID #: _____ Exp. Date: _____)

Full Legal Name: Last _____ First _____ M.I. _____

Mailing Address: _____

City, State, Zip: _____

Physical Address (if different than mailing): _____

City, State, Zip: _____ Telephone Number: _____

E-mail address **(OPTIONAL):** _____

2.) IDENTIFICATION INFORMATION (REQUIRED)

(Circle One) MALE FEMALE

Date of Birth: _____ Eye Color: _____ Weight: _____lbs. Height: _____ ft. _____ in.

***VALID* VERMONT** Driver's License or Non-Driver ID #: _____

3.) PROCUREMENT SELECTION (REQUIRED, check only one)

(***Please note***: Cultivators *do not* designate a dispensary. Patients who elect to cultivate, may *not* purchase marijuana from a dispensary. Patients who designate a dispensary for purchasing marijuana, *cannot* cultivate marijuana or change dispensaries for 30 days.)

☐ Champlain Valley Dispensary (Burlington)

☐ Grassroots Vermont (Brandon)

☐ Southern Vermont Wellness (Brattleboro)

☐ Vermont Patients Alliance (Montpelier)

☐ Cultivate (Provide cultivation address and location within building): _____

_____

4.) DISPENSARY COMMUNICATION (OPTIONAL)

☐ Checking this box will allow the Vermont Marijuana Registry (VMR) to provide your contact information to your designated dispensary. Additionally, you will be eligible to receive delivery services from your designated dispensary, if desired. The dispensaries are required to treat patient information as confidential. This authorization may be withdrawn at any time.

OFFICE USE ONLY: M.O. /CK #:_____ Amount: $_____ M.O. /CK Date: _____
SAVED PHOTO: Yes _____ No _____ Date: _____ HCPF VERIFIED: Yes _____ No _____ Date: _____
NOTES: _____

Registered Patient Acknowledgements (REQUIRED)

Instructions: ***ALL*** statements below ***MUST*** be ***INITIALED*** signifying you have read and understand the information.

_____ I understand if my application is approved, my registration is valid for *one year* and marijuana may *only* be used for symptom relief.

_____ I understand it is my responsibility to renew annually with the VMR by submitting the *required* completed application with a non-refundable $50 fee to the VMR 30 days before my expiration date to prevent a lapse in status but no more than 90 days before my expiration date. Additionally, I understand that I must report a lost or stolen registry identification card to the VMR within 10 business days.

_____ I understand the use of marijuana is *prohibited*; on the property of a registered dispensary; in any public place, while operating a motor vehicle, boat, or any other vehicle propelled or drawn by power other than muscular power; in a workplace; operating heavy machinery or handling a dangerous instrumentality; or in a manner that endangers the health or well-being of another person.

_____ I understand if my application is denied the decision may be appealed. The Notice of Appeal *must* be submitted within 7 days and the review is limited to the information submitted with this application and consultation with my Health Care Professional.

_____ I understand if my application is approved and I elect to cultivate, marijuana plants *must* be grown in the single secure indoor facility identified on this application. A secure indoor facility means a building or room equipped with locks or other security devices that *only* permits access to me (and my registered caregiver(s), if applicable).

_____ I understand if my application is approved and I elect to cultivate in my identified single secure indoor facility, I may possess *no more* than 2 mature plants, 7 immature plants, and 2 ounces of usable marijuana.

_____ I understand if my application is approved and I elect to cultivate, I *may not* purchase usable marijuana from a dispensary but may purchase clones or seeds to assist in the cultivation process.

_____ I understand if my application is approved and I designate a dispensary, I may possess no more than 2 ounces of usable marijuana and *may not* cultivate marijuana. Additionally, I may only change my designated dispensary once every 30 days.

_____ I understand if my application is approved, marijuana *may not* be transported in public, including in a motor vehicle except in a locked container; this includes transporting marijuana from a dispensary.

_____ I understand a Law Enforcement Officer is *not* required to return marijuana or paraphernalia after seizure. Additionally, Law Enforcement that discovers marijuana cultivation occurring in a manner other than permitted, by 18 V.S.A. Chapter 86 or the Rules governing the VMR, are *not* required to return seized marijuana or paraphernalia and criminal penalties may apply.

_____ I have instructed my registered caregiver(s) or next of kin, in the event of my death, the VMR *must* be notified within 72 hours and arrange for disposal of any and all marijuana and/or marijuana plants.

_____ I understand that providing false information on this application or to Law Enforcement, may result in imprisonment, a fine, or both. This penalty may be in addition to other penalties that may apply.

_____ I understand the possession of marijuana remains a violation of Federal Law and Vermont Law *does not* provide protections against Federal Law violations.

_____ I understand that my health insurer is not required to cover or reimburse the cost of marijuana for symptom relief.

THE APPROPRIATE SECTION OF THIS PAGE ***MUST*** BE COMPLETED

INITIAL *PATIENT APPLICANTS MUST COMPLETE THIS SECTION*

NOTARY REQUIRED

I swear under oath that I have read and understand the Registered Patient Acknowledgements and that by my signature I acknowledge that the information I have provided in this application is true and accurate. I personally appeared and identified myself before the Notary Public certifying this document.

Patient Applicant Signature: _____ *Date*: _____

Subscribed and duly sworn before me on _____ _____, 20_____.
(month) (day) (year)

Notary Public Signature: _____ *Commission exp. date*: _____ _____, 20_____.
(month) (day) (year)

RENEWAL *PATIENT APPLICANTS MUST COMPLETE THIS SECTION*

SIGNATURE REQUIRED

I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate. I certify that I have read and understand the Registered Patient Acknowledgements.

Patient Applicant Signature: _____ *Date*: _____

THIS SECTION IS ONLY REQUIRED FOR PATIENTS ***UNDER 18 YEARS OLD***

Or if the patient has a court appointed guardian or durable power of attorney*:*

I hereby warrant that I am a legally competent adult and a parent or court appointed guardian of the patient applicant and that I have the right to contract for the patient applicant. I have read and fully understand the contents of this application and certify the information provided on this application is true and accurate.

Parent or Guardian Signature: _____

PRINT LEGAL NAME Last: _____ First: _____ M.I. _____

Mailing Address: _____

City, State, Zip _____

If the patient applicant has a court *appointed a guardian* or durable power of attorney, please attach proof of guardianship or power of attorney.

Registered Caregiver Designation (OPTIONAL)

Instructions: ***If the patient applicant wants to designate a caregiver, the following 3 pages must be completed by the person the patient has selected***. *This section is not to be completed by the patient.* If the patient's preference is to not designate a caregiver at this time the following 3 pages are not required to be completed. A caregiver *cannot* be a currently registered patient or caregiver. A registered caregiver may assist only one registered patient with cultivation or obtaining marijuana from the patient's designated dispensary. **All caregiver applicants must be submitted with a $50 fee payable to the Department of Public Safety. This fee is in addition to the fee for the patient application.** Initial applications must submit a color photo of the applicant's upper body on a CD with the application or via email to DPS.MJRegistry@vermont.gov prior mailing the application. Renewal applications are not required to submit a photo.

Note: Patient applicants under the age of 18 may register 2 caregivers; each caregiver must complete this section or complete the "Registered Caregiver Application".

1.) CAREGIVER APPLICANT INFORMATION

☐ Initial Application ☐ Renewal Application (ID #: _____ Exp. Date: _____)

Full Legal Name: Last _____ First _____ M.I. _____

Maiden or Alias Name(s): _____

Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

Physical Address (if different than mailing): _____

City, State, Zip: _____ Social Security Number: _____

Place of Birth (City/Town): _____ State: _____ Country: _____

E-mail address: _____

***VALID* VERMONT** Driver's License or Non-Driver ID #: _____

In addition to Vermont, I have resided or been employed in the following states (List all that apply): _____

_____

2.) IDENTIFICATION INFORMATION

(Circle One) MALE FEMALE

Date of Birth: _____ Eye Color: _____ Weight: _____lbs. Height: _____ ft. _____ in.

3.) DISPENSARY COMMUNICATION (OPTIONAL)

☐ Checking this box will allow the Vermont Marijuana Registry (VMR) to provide your contact information to your patient's designated dispensary. Additionally, you will be eligible to receive delivery services from your designated dispensary, if desired. The information received by the dispensary is confidential. The dispensaries are required to treat caregiver information as confidential. This authorization may be withdrawn at any time.

OFFICE USE ONLY: M.O. /CK #: _____ Amount: $ _____ M.O. /CK Date: _____
SAVED PHOTO: Yes _____ No _____ Date: _____ CHRC: Approved _____ Denied _____ Date: _____

NOTES: _____

Registered Caregiver Acknowledgements

Instructions: ***ALL*** statements below ***MUST*** be ***INITIALED*** signifying you have read and understand the information.

_____ I understand a registered caregiver can *only* care for **ONE** registered patient and must be at least 21 years old.

_____ I understand that applying as a caregiver indicates undertaking responsibility for managing my registered patient's well-being with respect to the use of marijuana for symptom relief. This may include assisting my registered patient with cultivation or obtaining marijuana from their designated dispensary.

_____ I understand if my application is approved, my registration is valid for *one year*.

_____ I understand it is my responsibility to renew annually with the VMR by submitting the required completed application with a non-refundable $50 fee to the VMR 30 days before my expiration date to prevent a lapse in status but no more than 90 days before my expiration date. Additionally, I understand that I must report a lost or stolen registry identification card to the VMR within 10 business days.

_____ I understand that I must consent to a criminal record check conducted by the VMR. The criminal record check includes Vermont, out-of-state, and FBI criminal records.

_____ I understand that if my application is denied due to a criminal conviction(s) a copy of the record will be sent for review. The accuracy and completeness of the criminal record may be appealed in writing within 7 days.

_____ I understand that if my application is approved and my registered patient elects to cultivate, marijuana plants must be grown in a single secure indoor facility. A secure indoor facility means a building or room equipped with locks or other security devices that *only* allows access to me and my registered patient.

_____ I understand if my registered patient elects to cultivate the possession limit, between me and my registered patient, is *no more* than 2 ounces of usable marijuana, 2 mature marijuana plants and 7 immature marijuana plants.

_____ I understand if my registered patient elects to cultivate, we *may not* purchase usable marijuana but may purchase clones or seeds from a dispensary.

_____ I understand if my registered patient designates a dispensary, *no more* than 2 ounces of usable marijuana may collectively be in possession by me and my registered patient at any time and we *may not* cultivate marijuana plants.

_____ I understand that a registered caregiver is *not* authorized to use marijuana and my use of marijuana can be subject to criminal penalties.

_____ I understand marijuana *may not* be transported in public, including in a motor vehicle except in a locked container; this includes transporting marijuana from a dispensary.

_____ I understand in the event of the death of my registered patient, I *must* notify the VMR within 72 hours and arrange for the disposal of any marijuana or marijuana plants.

_____ I understand that a Law Enforcement Officer is *not* required to return marijuana or paraphernalia after seizure. Additionally, Law Enforcement that discovers marijuana cultivation occurring in a manner other than permitted, by the Rules or law governing the VMR, are *not* required to return seized marijuana or paraphernalia.

_____ I understand that providing false information on this application or to Law Enforcement, may result in imprisonment, a fine, or both. This penalty may be in addition to other penalties that may apply.

_____ I understand that the possession and distribution of marijuana remains a violation of Federal Law and Vermont Law does *not* provide protection against a violation of Federal Law.

Registered Caregiver Release Form

I hereby acknowledge and consent to a review of any criminal records obtained from the Vermont Crime Information Center, out-of-state law enforcement agencies, and the Federal Bureau of Investigation. I understand that the results will be made available to the VMR for determining my eligibility as a registered caregiver, as specified in Title 18 V.S.A. Chapter 86.

Additionally, I declare under pains and penalty of perjury that the information provided on this form is true and accurate and that I have read and understood the Registered Caregiver Acknowledgements.

Caregiver Applicant Signature ***REQUIRED***: _____ Date: _____

HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant's health care professional and signed within the last 6 months. **This form *and* a Registered Patient Application *MUST* be completed and submitted for initial and renewal applicants.** The definitions below are provided to assist health care professionals when completing this form.

DEFINITIONS:

"Bona fide health care professional-patient relationship" means:

A treating or consulting relationship of not less than three months' duration, in the course of which a health care professional has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination.

(B) The three-month requirement shall not apply if a patient has been diagnosed with:

(I) A terminal illness;

(II) Cancer;

(III) Acquired immune deficiency syndrome; or

(IV) Is currently under hospice care.

(ii) A patient had been diagnosed with a debilitating medical condition by a health care professional in another jurisdiction in which the patient had been formerly a resident and the patient, now a resident of Vermont, has the diagnosis confirmed by a health care professional in this State or a neighboring state as provided in subdivision (6) of this section, and the new health care professional has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.

(iii) A patient who is already on the registry changes health care professionals three months or less prior to the annual renewal of the patient's registration, provided the patient's new health care professional has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.

"Health care professional" means an individual who is:

A) Licensed as a physician or osteopathic physician under 26 V.S.A Chapter 23 or Chapter 33;
B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
C) Certified as a physician's assistant under 26 V.S.A. Chapter 31; or
D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28.

This definition includes professionally licensed individuals under substantially equivalent provisions in New Hampshire, Massachusetts, or New York.

"Debilitating medical condition" means reasonable medical efforts have been made over a reasonable amount of time to relieve the symptoms related to a disease, medical condition, or its treatment described in subdivision (A) or (B):

A) Cancer, acquired immune deficiency syndrome, positive status for human immunodeficiency virus, glaucoma, multiple sclerosis; or

B) A disease, medical condition, or its treatment that is chronic, debilitating and produces and one or more of the following intractable symptoms: cachexia or wasting syndrome, chronic pain, severe nausea, or seizures.

An applicant lacking a "debilitating medical condition" is not eligible for a registry identification card.

HEALTH CARE PROFESSIONAL VERIFICATION FORM

The Vermont Marijuana Registry (VMR) will contact the health care professional completing this form to confirm the accuracy of the information contained on this form.

ALL SECTIONS MUST BE COMPLETED

1) PATIENT APPLICANT'S INFORMATION (Please print legibly)

Full Legal Name: Last _____ First _____ M.I. _____

Date of Birth: _____ Telephone Number: _____

2) HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

Full Legal Name: Last _____ First _____ M.I. _____

Office Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

3) HEALTH CARE PROFESSIONAL LICENSE INFORMATION:

State Issued License Number: _____ Issuing State (circle one): VT NH MA NY

4) LICENSURE CATEGORY

☐ Doctor of Medicine ☐ Physician Assistant ☐ Naturopathic Physician

☐ Osteopathic Physician ☐ Advanced Practice Registered Nurse

5) VERIFICATION OF A DEBILITATING MEDICAL CONDITION

The patient applicant I am treating or consulting:

☐ Does not have a debilitating medical condition as defined.

☐ Has been diagnosed with **cancer**.

☐ Has been diagnosed with **acquired immune deficiency syndrome**.

☐ Has been diagnosed with **human immunodeficiency virus**.

☐ Has been diagnosed with **multiple sclerosis**.

☐ Has been diagnosed with **glaucoma.**

☐ Has been diagnosed with a disease, medical condition, or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed below in subdivision B. ***(Subsections A and B MUST be completed***)

(A) Indicate specific diagnosis: _____

(B) Indicate specific symptom (*circle all that apply*): cachexia chronic pain severe nausea seizures

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OFFICE USE ONLY – HCPF VERIFIED: Yes _____ No _____ Date: _____ NOTES: _____

_____

6) BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP STATEMENT (Check all that apply A-F)

A) ☐ I **HAVE** a treating or consulting relationship with the patient named on this form of at least *three months'* duration.

☐ I **DO NOT** have a treating or consulting relationship with the patient named on this form of at least *three months'* duration.

B) ☐ I **HAVE** completed a *full assessment* of the patient's medical history and current medical condition, including a personal physical examination.

☐ I have **NOT** completed a *full assessment* of the patient's medical history and current medical condition, including a personal physical examination.

C) ☐ The patient applicant has been diagnosed with:

I. ☐ A terminal illness (or is currently under hospice care);

II. ☐ Cancer; or,

III. ☐ Acquired immune deficiency syndrome.

D) ☐ The patient applicant I am treating or consulting has been diagnosed with a debilitating medical condition in another jurisdiction where the patient was formerly a resident and the patient is now a resident of Vermont.

E) ☐ The patient applicant I am treating or consulting is already registered with the VMR **AND** has changed health care professionals within the last three months.

F) ☐ The patient's medical condition **IS** of recent or sudden onset and the patient has not had a previous health care professional who is able to verify the nature of the disease and its symptoms.

I. ☐ The patient's medical condition was diagnosed on: _____/_____/_____ (MM/DD/YYYY)

ATTESTATION OF INFORMATION

I certify:

1) I am a health care professional;
   A) Licensed as a *physician* or *osteopathic physician* under 26 V.S.A Chapter 23 or Chapter 33;
   B) Licensed as a *naturopathic physician* under 26 V.S.A Chapter 81;
   C) Certified as a *physician's assistant* under 26 V.S.A Chapter 31;
   D) Licensed as an *advanced practice registered nurse* under 26 V.S.A Chapter 28; or,
   E) Professional licensed under substantially equivalent provisions in NH, MA, or NY.
2) I am in good standing with the state (VT, NH, MA, or NY) regulating my professional license, and that the facts stated above are true and accurate to the best of my knowledge and belief.
3) Reasonable medical efforts have been made over a reasonable amount of time to relieve the patient's symptoms.
4) I understand, notwithstanding any law to the contrary, a person who knowingly provides false information on this application may be guilty of perjury and imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply.

This form is to verify the nature of the disease and its symptoms; this is not a prescription or medical recommendation for the use of marijuana.

Health Care Professional's Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS SECTION MUST BE COMPLETED BY THE PATIENT APPLICANT

I hereby authorize the health care professional named on this form to release my protected medical information to the Vermont Marijuana Registry (VMR) to verify and confirm the accuracy of the information contained within this form. I authorize the named health care professional to:

- Disclose the nature, symptoms, and duration of the medical condition identified on this form for the purpose of determining that it meets the legal definition of a debilitating medical condition on page 1 of this form;
- Disclose whether the named health care professional and I have a bona fide health care professional-patient relationship, as defined by law and on page 1 of this form;
- Confirm the accuracy of the information contained in this form.

I understand that any information released to the VMR will be used solely to confirm the accuracy of the information contained in this form. While the information will no longer be covered by the HIPAA Privacy Rule, Vermont law requires the VMR to keep all information confidential, except for the prosecution of false swearing. I understand this authorization is valid for one year from the date the VMR receives this form, unless a written communication revoking this authorization or a new authorization is received by the VMR. I understand that I have the right to revoke this authorization at any time by notifying both the health care professional named on this form and to the VMR in writing.

Patient Applicant Signature REQUIRED: _____ Date: _____

*If the patient applicant is **under the age of 18** or has a **court appointed guardian** the section below must be completed:*

Parent or Guardian Signature: _____ Date: _____

APPLICATION CHECK SHEET

Carefully review the appropriate check list below prior to submitting your application to the VMR, incomplete applications may be returned and delay processing. The VMR will process complete applications within 30 days from receipt.

INITIAL APPLICANTS

☐ 1) Have sections 1 thru 3 been completed on page 1?

☐ 2) On page 1, under section 3, has only one box been checked?

☐ 3) If you selected to "Cultivate" on page 1, did you provide the cultivation address and location within building?

☐ 4) Have you initialed ***all*** the Acknowledgements on page 2?

☐ 5) Has the application been notarized and dated on page 3?

☐ 6) Have you enclosed a completed Health Care Professional Verification Form?

☐ 7) Have you enclosed a check or money order for the appropriate fee payable to the Department of Public Safety? (***Fees****: $50 Patient application and $50 for each Caregiver application*)

☐ 8) Verify the check or money order has been signed, dated, and the correct amount written out.

☐ 9) Have you enclosed a CD with a **color** photo or emailed a **color** photo of yourself to DPS.MJRegistry@vermont.gov? a.) Photos submitted via *email* must be sent prior mailing this application and include your name and date of birth. b.) Photos submitted on a *CD* must be sent with this application and have your name and date of birth on the CD. *(*Note:* *The color photo must be of the applicant(s) upper body. Copies of photos will NOT be accepted.)*

☐ 10) If designating a caregiver, have pages 4, 5, and 6 been completed by the caregiver applicant? *Note: Caregiver applicants must submit a photo and fee (see 7 thru 9 above.)*

RENEWAL APPLICANTS

☐ 1) Have sections 1 thru 3 been completed on page 1?

☐ 2) On page 1, under section 3, has only one box been checked?

☐ 3) If you selected to "Cultivate" on page 1, did you provide the cultivation address and location within building?

☐ 4) Have you initialed ***all*** the Acknowledgements on page 2?

☐ 5) Has the application been signed and dated on page 3?

☐ 6) Have you enclosed a completed Health Care Professional Verification Form?

☐ 7) Have you enclosed a check or money order for the appropriate fee payable to the Department of Public Safety? (***Fees****: $50 Patient application and $50 for each Caregiver application*)

☐ 8) Verify the check or money order has been signed, dated, and the correct amount written out.

☐ 9) Has your appearance significantly changed? If yes, see #9 of the "Initial applicants" section above.

☐ 10) If designating a caregiver, have pages 4, 5, and 6 been completed by the caregiver applicant?

ALL COMPLETED APPLICATIONS MUST BE MAILED TO:

Department of Public Safety
Marijuana Registry
45 State Drive
Waterbury, VT 05671-1300