State of Vermont
Marijuana Registry
45 State Drive
Waterbury, Vermont 05671-1300
www.medicalmarijuana.vermont.gov

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

CAREGIVER APPLICATION

APPLICATION CHECK SHEET

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

1) ☐ Have you completed pages 1-3?

2) ☐ Have you submitted a photo following the instructions on page 3?
(*Renewal applicants do NOT need to submit a photo)*

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

4) ☐ Have you enclosed a check or money order for the appropriate non-refundable fee payable to the Department of Public Safety? (***Fee****: $50 for each Caregiver application*)

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

MAIL COMPLETED APPLICATIONS TO:

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

VERMONT

REGISTERED CAREGIVER APPLICATION

Instructions: Carefully review all pages. *Clearly* complete ALL sections, unless labeled optional. Incomplete applications will be returned. A registered caregiver may assist one registered patient with cultivation or may accompany his or her patient to the dispensary and be present during appointments in the dispensing room. **All caregiver applications must be submitted with a non-refundable $50 check or money order payable to the Department of Public Safety.** *Note:* A registered patient under the age of 18 may have 2 designated caregivers; each caregiver must complete a Caregiver application. Contact the Registry with any questions.

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

1) **REGISTERED PATIENT INFORMATION** (Specify the patient designating you as their registered caregiver)

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

2) **CAREGIVER APPLICANT INFORMATION**

Application Type (check one): ☐ 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: _____

Gender (circle one): *MALE* *FEMALE* Eye Color: _____ Weight: _____lbs. Height: ___ ft. _____ in.

Date of Birth: _____ ****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): _____

_____

3) **DISPENSARY COMMUNICATION & DELIVERY** (*Dispensaries are **REQUIRED** to maintain **ALL** patient and caregiver information as confidential in conformity with HIPAA.* This authorization may be withdrawn at any time.)

May the Vermont Marijuana Registry (VMR) provide your address, phone number, and email (if applicable) to your patient's designated dispensary? ☐ ***Yes*** ☐ ***No***

(Checking ***Yes*** will enable you to receive **delivery** for your patient and the dispensary will be able to contact you about appointment(s), if needed. *ONLY* the VMR and your dispensary will have your information.)

OFFICE USE ONLY: Funds #: _____ Amount: $_____ Funds Date: _____

PHOTO: Yes No Date: _____ CHRC: Approved Denied Initials: _____ Date: _____

NOTES: _____

Instructions: Read ***ALL*** the statements below. Once you have read all the statements, ***initial*** each statement signifying you have read and understand the information. If you do not understand any of the statements below, contact the VMR**.**

3.) **Caregiver Acknowledgements**

_____ 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.

_____ I understand a lost or stolen registry identification card *MUST* be reported 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 to me for review. The accuracy and completeness of the criminal record may be appealed in writing within 7 days.

_____ I understand the amount of marijuana a registered patient and their caregiver ***collectively*** may possess is *no more than* 2 mature marijuana plants, 7 immature plants, and 2 ounces of usable marijuana at the same time.

_____ I understand if my application is approved, I *MUST* present my valid registry identification card to dispensary personnel at an appointment and at the time of delivery.

_____ I understand in the event of the death of my registered patient, I *MUST* notify the VMR within 72 hours.

_____ I understand that a Law Enforcement Officer is *not* required to return marijuana or paraphernalia after seizure.

_____ I understand providing false information on this application or to Law Enforcement, may result in criminal penalties.

_____ I understand Vermont Law *does not* provide protections against Federal Law violations and does not apply to conduct that occurs outside of the State of Vermont.

4.) **Caregiver Photo Requirements**

Instructions: Initial applicants ***MUST*** submit a digital photo. Renewal applicants, if your appearance has significantly changed, an updated digital photo must be submitted.

Your photo must be:

- In color and reflect your current appearance (taken within the last 6 months);
- A clear image of ONLY you (not blurry, grainy, or fuzzy);
- Full face-and-shoulder shot, squarely facing the camera (no sunglasses);

Additional Tips

- Please email your photo prior to mailing your application.
- Do not scan your driver's license or another photo ID. The scanned image will not be of high enough quality to meet the requirements.
- Do not submit a photo of a photo ***(just take a photo of yourself)***.

Submitting a Photo – To submit a photo, send an email from your computer, cell phone, or mobile device with the following information:

- Subject Line: Your first and last name
- Include your date of birth with your first and last name in the body of the email.
- Attach your photo
- Email Address: DPS.MJRegistry@vermont.gov
- Receipt: An email will be sent by the VMR staff confirming acceptance of your photo.

If you are unable to email a photo, a photo may be submitted on a CD.

5.) **Registered Caregiver Release Form**

SIGNATURE REQUIRED

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*: _____ ***Date:* _____

Designating Registered Patient must complete this section

As a registered patient, my sole preference is to designate this applicant as my registered caregiver to provide assistance with the use of marijuana for symptom relief.

Patient Signature REQUIRED: _____ ID#:_____ Date: _____

ONLY REQUIRED FOR PATIENTS ***UNDER 18 YEARS OLD***

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

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

Parent or Guardian Signature: _____ Date: _____