



**State of Vermont**  
**Marijuana Registry**  
 45 State Drive  
 Waterbury, Vermont 05671-1300  
[www.medicalmarijuana.vermont.gov](http://www.medicalmarijuana.vermont.gov)

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

Department of Public Safety

## **PATIENT REGISTRATION PACKET**

*(Includes Patient application, Caregiver application, Health Care Professional Verification Form, and Mental Health Care Provider Form)*

### **APPLICATION CHECK SHEET**

**Instructions:** *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.

#### **INITIAL APPLICANTS**

- 1) Have you completed pages 1-3?
- 2) Have you submitted a photo following the instructions on page 3?
- 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) Have you enclosed a completed Health Care Professional Verification Form?
- 6) Have you enclosed a check or money order for the appropriate non-refundable fee payable to the Department of Public Safety? (**Fees:** \$50 to register as a patient and a \$50 fee to register a caregiver. Minors applying as a patient may have 2 caregivers and the fee is waived for a parent/guardian applying as a caregiver.)
- 7) Verify the check or money order has been signed, dated, and the correct amount written out.
- 8) If designating a caregiver, has the person applying to be a caregiver completed pages 4-6?

#### **RENEWAL APPLICANTS**

**Note:** IF YOUR REGISTRY ID CARD EXPIRED LESS THAN 3 YEARS AGO YOU ARE CONSIDERED A RENEWAL.

- 1) Have you completed pages 1-3?
- 2) If you selected to “Cultivate” on page 1, did you provide the cultivation address and location within building?
- 3) Have you initialed all the Acknowledgements on page 2?
- 4) Have you enclosed a completed Health Care Professional Verification Form?
- 5) Have you enclosed a check or money order for the appropriate non-refundable fee payable to the Department of Public Safety? (**Fees:** \$50 Patient application and \$50 for each Caregiver application)
- 6) Verify the check or money order has been signed, dated, and the correct amount written out.
- 7) If designating a caregiver, has the person applying to be a caregiver completed pages 4-6?

#### **MAIL COMPLETED APPLICATIONS TO:**

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



**PATIENT REGISTRATION PACKET**

Includes Patient application, Caregiver application, Health Care Professional Verification Form, & Mental Health Care Provider Form

**Instructions:** Carefully review all pages. Clearly complete ALL sections, unless labeled optional. Incomplete applications will be returned for completion. All patient applications **must** be submitted with a non-refundable \$50 check or money order made payable to the Department of Public Safety.

**1.) \*\*PATIENT INFORMATION\*\***

Application Type (check one):  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): \_\_\_\_\_

Gender (circle one): *MALE* *FEMALE* Eye Color: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Height: \_\_\_ ft. \_\_\_ in.

Date of Birth: \_\_\_\_\_ \*VALID\* VERMONT Driver's License or Non-Driver ID #: \_\_\_\_\_

**2.) \*\*DISPENSARY DESIGNATION\*\*** (Select only **ONE** dispensary. If more than one location is listed for below for a dispensary appointment may be scheduled at either location.)

- Champlain Valley Dispensary (*Burlington & South Burlington*)  Grassroots Vermont (*Brandon*)
- PhytoCare Vermont (*Bennington*)  Southern Vermont Wellness (*Brattleboro & Middlebury*)
- Vermont Patients Alliance (*Montpelier*)

**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 designated dispensary?  *Yes*  *No*

(Checking *Yes* will allow you to receive **delivery** services and your dispensary will be able to contact you about your appointment(s), if needed. The VMR will **ONLY** provide your information to your dispensary.)

**4.) \*\*CULTIVATION\*\***

Do you plan on cultivating marijuana in the next 12 months?  *Yes*  *No*

If you selected *Yes*, the section below **MUST** be completed.

Secure Indoor Facility Information:

Physical address (where marijuana will be cultivated): \_\_\_\_\_

Location within building: \_\_\_\_\_

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**OFFICE USE ONLY:** Funds #: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Funds Date: \_\_\_\_\_ Photo: *Yes* *No* Date: \_\_\_\_\_

HCP VERIFIED: *Yes* *No* Date: \_\_\_\_\_ Caregiver: Approved Denied Initials: \_\_\_\_\_ 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.

5.) **\*\*Patient Acknowledgements\*\***

- \_\_\_\_\_ 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.
- \_\_\_\_\_ I understand if I want a person to accompany me to the dispensary AND be present during my appointment in the dispensing room he or she MUST register as my caregiver with the VMR.
- \_\_\_\_\_ I understand a lost or stolen registry identification card MUST be reported 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 motorized vehicle; in a workplace; operating heavy machinery or handling a dangerous instrumentality; or that endangers the health or well-being of another person.
- \_\_\_\_\_ I understand if my application is denied the decision may be appealed within 7 days and is reviewed based on the information submitted with this application and consultation with my Health Care Professional.
- \_\_\_\_\_ 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 and want to cultivate, I MUST identify a single secure indoor facility on this application.
- \_\_\_\_\_ I understand if my application is approved, I may purchase marijuana and marijuana products, including seeds and clones from my designated dispensary.
- \_\_\_\_\_ 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 if my application is approved, I may only change my designated dispensary once every 30 days.
- \_\_\_\_\_ I understand a Law Enforcement Officer is not required to return marijuana or paraphernalia after seizure.
- \_\_\_\_\_ I have instructed my registered caregiver(s) or next of kin, in the event of my death, they must notify the VMR within 72 hours.
- \_\_\_\_\_ I understand providing false information on this application or to Law Enforcement may result in criminal penalties.
- \_\_\_\_\_ I understand the possession and cultivation of marijuana remains a violation of Federal Law.
- \_\_\_\_\_ 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.
- \_\_\_\_\_ I understand that my health insurer is not required to cover or reimburse the cost of marijuana for symptom relief.



6.) **\*\*Patient Photo Requirements\*\***

**Instructions:** Initial applicants **MUST** submit a digital photo. Renewal applicants are not required to submit a digital photo, unless your appearance has significantly changed.

**Your photo must be:**

- In color;
- 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**

- 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](mailto:DPS.MJRegistry@vermont.gov)
- Receipt: A 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.

7.) **\*\*Patient Signature\*\***

**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: \_\_\_\_\_

**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, if not previously submitted.

**MAIL COMPLETED APPLICATIONS TO:**

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



**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.* A registered caregiver may assist one registered patient with cultivation or obtaining marijuana from the patient’s designated dispensary. A registered caregiver 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 \$50 fee payable to the Department of Public Safety. This fee is in addition to the fee for the patient application.**

*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\*\***

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): \_\_\_\_\_

**2.) \*\*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**

(By checking **Yes** you will be eligible 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.)

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**OFFICE USE ONLY:** M.O./CK #: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ M.O./CK Date: \_\_\_\_\_

PHOTO: Yes No Date: \_\_\_\_\_ CHRC: Approved Denied 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 that a registered caregiver is not authorized to use marijuana and my use of marijuana can be subject to criminal penalties.
- \_\_\_\_\_ 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 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.
- \_\_\_\_\_ 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 are not required to submit a digital photo, unless your appearance has significantly changed.

**Your photo must be:**

- In color;
- 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**

- 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](mailto:DPS.MJRegistry@vermont.gov)
- Receipt: A 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:** \_\_\_\_\_

**MAIL COMPLETED APPLICATIONS TO:**

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



## **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 must be completed and submitted with a Registered Patient Application.** The definitions below are provided to assist health care professionals when completing this form.

*This verification form is **NOT** considered a **prescription** and the only purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined.*

*Notwithstanding any law to the contrary, a person who knowingly gives to any law enforcement officer false information to avoid arrest or prosecution, or to assist another in avoiding arrest or prosecution, shall be imprisoned for not more than one year or fined not more than \$1,000.00 or both.*

### **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.

**"Debilitating medical condition"** means:

- A) Cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, glaucoma, Crohn's disease, Parkinson's disease or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms;
- B) Post-traumatic stress disorder, provided the Department confirms the applicant is undergoing psychotherapy or counseling with a licensed mental health care provider; or
- C) A disease or 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.

**"Health care professional"** means an individual who is:

- A) Licensed to practice medicine 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 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 individuals who are professionally licensed under substantially equivalent provisions in New Hampshire, Massachusetts, or New York.

**Patients diagnosed with PTSD are also required to submit a completed Mental Health Care Provider Form to the VMR.**

*An applicant without 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 confirming the accuracy of the information.

**SECTIONS #1 – #6 MUST BE COMPLETED and submitted with a completed Registered Patient Application**

This verification form is NOT considered a prescription and the only purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined.

**1) PATIENT 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:**

License Number: \_\_\_\_\_ Issuing State (circle one): VT NH MA NY

**4) LICENSURE CATEGORY**

- Doctor of Medicine       Osteopathic Physician       Naturopathic Physician
- Physician Assistant       Advanced Practice Registered Nurse

**5) VERIFICATION OF A DEBILITATING MEDICAL CONDITION**

(A) Does the patient applicant have a debilitating medical condition as defined on the Cover Sheet?

- No       Yes (if "Yes", Section B **MUST** be completed)

(B) The patient applicant I am treating or consulting has been diagnosed with (check all that apply):

- Acquired Immune Deficiency Syndrome       Glaucoma
- Cancer       Human Immunodeficiency Virus
- Crohn's Disease       Multiple Sclerosis
- Parkinson's Disease
- \*Post-Traumatic Stress Disorder (\*A Mental Health Care Provider Form is required to be completed and submitted to the VMR)
- A disease or medical condition or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed in subdivision B. (**\*\*Subsections I and II MUST be completed\*\***)

I.) **\*\*Indicate specific diagnosis\*\***: \_\_\_\_\_

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

OFFICE USE ONLY – HCPF VERIFIED: Yes No DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ NOTES: \_\_\_\_\_



6) **BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP INFORMATION**

- (A) Have you completed a full assessment of the patient applicant’s medical history and current medical condition, including a personal physical examination?  
 Yes             No
- (B) Do you have a treating or consulting relationship with the patient application of at least three (3) months?  
 Yes             No
- (C) Has the patient applicant been diagnosed with a terminal illness and/or currently under hospice care?  
 Yes             No
- (D) Was the patient applicant diagnosed in another state or jurisdiction where they formally resided and moved to Vermont within the last three (3) months?  
 Yes             No
- (E) Was the patient applicant diagnosed with the debilitating medical condition specified on the previous page within the last three (3) months?  
 Yes (Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_)     No
- (F) Was the patient applicant referred to you by another health care professional because of your advanced education and clinical training specific to the debilitating medical condition specified on the previous page?  
 Yes             No

7) **HEALTH CARE PROFESSIONAL SIGNATURE**

I certify that:

- (A) I am a health care professional;
  - A) Licensed to practice medicine 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 assistant under 26 V.S.A. Chapter 31; or
  - 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.
- (B) I am in good standing with the state (VT, NH, MA, or NY) regulating my professional license, and that the facts stated on this Health Care Professional Verification Form are true and accurate to the best of my knowledge and belief.
- (C) 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 verification form is not considered a prescription and that the only purpose of this verification form is to confirm that the applicant patient has a debilitating medical condition.***

Health Care Professional’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***This form must be completed and submitted with a Registered Patient Application to:***

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



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**THIS SECTION MUST BE COMPLETED BY THE PATIENT APPLICANT**

I hereby authorize the health care professional, and mental health care provider, if applicable, 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, and mental health care professional, if applicable, 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 mental health care professional, if applicable, 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: \_\_\_\_\_

**MAIL COMPLETED APPLICATIONS TO:**

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

**Questions?**

***Contact the Marijuana Registry***

***Phone:*** (802) 241-5115

***Email:*** [DPS.MJRegistry@vermont.gov](mailto:DPS.MJRegistry@vermont.gov)

***Website:*** [www.medicalmarijuana.vermont.gov](http://www.medicalmarijuana.vermont.gov)



**MENTAL HEALTH CARE PROVIDER FORM**

(REQUIRED FOR PATIENTS WITH **PTSD** INDICATED ON THE HEALTH CARE PROFESSIONAL VERIFICATION FORM.)

**Instructions:** This form *must* be completed and submitted for all applicants with Post-Traumatic Stress Disorder (PTSD) identified as the only debilitating medical condition on the Health Care Professional Verification Form. Vermont law requires the Vermont Marijuana Registry (VMR) to confirm applicants with PTSD are undergoing psychotherapy, or counseling with a licensed mental health care provider. The VMR may contact the mental health care provider completing this form to confirm the accuracy of the information contained on this form.

“Mental Health Care Provider” means:

“A person license to practice medicine who specializes in the practice of psychiatry; a psychologist, a psychologist-doctorate, or a psychologist-master as defined in 26 V.S.A. § 3001; a clinical social worker as defined in 26 V.S.A. § 3201; or a clinical mental health counselor as defined in 26 V.S.A. § 3261.”

**1. Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**2. Mental Health Care Professional Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Business Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**3. Licensure Information (\*\*Subsections A and B **MUST** be completed\*\*)**

- A.  Psychologist                       Psychologist-doctorate                       Psychologist-master
- Psychiatrist                               Clinical social worker                       Clinical mental health counselor
- Advanced Practice Registered Nurse (with Adult Psych and Mental Health Specialty)

B. License Number: \_\_\_\_\_

**4. Verification**

*I certify I am providing psychotherapy and/or counseling to the aforementioned patient. I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate.*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MAIL COMPLETED APPLICATIONS TO:**

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

**OFFICE USE ONLY: Notes:** \_\_\_\_\_