



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

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

Department of Public Safety

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



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:** _____