



**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

PATIENT REGISTRATION APPLICATION

(Includes Patient application and Caregiver application)

APPLICATION CHECK SHEET

Carefully review the appropriate check list below *prior to submitting your application* to the Vermont Marijuana Registry (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 Patient application and \$50 for each Caregiver application***)
- 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

- 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 APPLICATION

(Includes Patient application and Caregiver application)

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)

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

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**

(By checking **Yes** you will be eligible to receive **delivery** and your dispensary will be able to contact you about your appointment(s), if needed. ONLY the VMR and your dispensary will have your information.)

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: _____

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

HCP VERIFIED: **Yes No** Date: _____ Caregiver CHRC: 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 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, 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 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 if my application is approved, marijuana MUST be transported in a locked container in public and when leaving 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 Vermont law or the Rules governing the VMR, they are not required to return seized marijuana or paraphernalia and civil or criminal penalties may apply.
- _____ 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 and arrange for disposal of any and all marijuana and/or marijuana plants.
- _____ 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, 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.

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.



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. **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.)

OFFICE USE ONLY: Funds #: _____ Amount: \$ _____ Funds 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 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 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, marijuana MUST be transported in a locked container in public and when leaving a 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 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 Vermont law or the Rules governing the VMR, they are not required to return seized marijuana or paraphernalia and civil or criminal penalties may apply.
- _____ 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****

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- In color and reflect your current appearance (taken within the last 6 months);
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- 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:** _____