State of Vermont
Medical Cannabis Program
89 Main Street
Montpelier, Vermont 05620-7001
www.ccb.vermont.gov

[phone] 802-241-5115
[fax] 802-241-5230
[email] CCB.Med@vermont.gov

Cannabis Control Board

PATIENT REGISTRATION APPLICATION

APPLICATION CHECK SHEET

Carefully review the appropriate check list below *prior to submitting your application* to the Medical Cannabis Program (MCP), incomplete applications will be returned for completion and may delay processing. The MCP will process complete applications ***within*** 30 days of receipt**.**

INITIAL APPLICANTS

- ☐ 1) Have you completed pages 1 and 2?
- ☐ 2) Have you submitted a photo following the instructions on page 2?
- ☐ 3) If you selected to "Cultivate" on page 1, did you provide the cultivation address?
- ☐ 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 Vermont Medical Cannabis Program? *(**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.*)
- ☐ 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 3 and 4?

RENEWAL APPLICANTS

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

- ☐ 1) Have you completed pages 1 and 2?
- ☐ 2) If you selected to "Cultivate" on page 1, did you provide the cultivation address?
- ☐ 3) Have you enclosed a ***completed*** Health Care Professional Verification Form?
- ☐ 4) Have you enclosed a check or money order for the appropriate non-refundable fee payable to the Vermont Medical Cannabis Program? *(**Fees**: $50 Patient application and $50 for each Caregiver application*)
- ☐ 5) Verify the check or money order has been signed, dated, and the correct amount written out.
- ☐ 6) If designating a caregiver, has the person applying to be a caregiver completed pages 3 and 4?

MAIL COMPLETED APPLICATIONS TO:

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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 Vermont Medical Cannabis Program.

1.) **PATIENT INFORMATION**

Application Type (check one): ☐ Initial Application ☐ Renewal Application (ID #: _______________ Exp. Date: _________)

First Name: ______________________ M.I. ____ Last Name: ____________________ Date of Birth: ___________

Physical Address: ____Apt./Unit/Suite: _________________

City, State, Zip: ____

Mailing Address (if different than mailing): ________________________________ Apt./Unit/Suite: _______________

City, State, Zip: ____

Telephone Number: ________________________ E-mail address**:** _________________________________

Gender: ________________ Eye Color: _______________ Weight: _________lbs. Height: _____ ft. ______ in.

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

2.) **DISPENSARY DESIGNATION** (Select only **ONE** dispensary. If more than one town is listed next to the dispensary an appointment may be scheduled at either location.)

☐ CeresMED ***(Burlington & South Burlington)***
☐ CeresMED South ***(Brattleboro & Middlebury)***
☐ Grassroots Vermont ***(Brandon)***
☐ PhytoCare Vermont ***(Bennington)***
☐ 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 Medical Cannabis Program (MCP) 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 MCP will *ONLY* provide your information to your dispensary.)

4.) ** CULTIVATION**

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

If you selected ***Yes***, provide the physical address where cannabis will be grown below.

Physical address (where cannabis will be cultivated): ____

OFFICE USE ONLY: Funds #: ______________________ Amount: $_______ Funds Date: _________ Photo: ***Yes*** ***No*** Date: _______

HCP VERIFIED: ***Yes*** ***No*** Date: ___________ Caregiver: Approved Denied Initials: ________ NOTES: __________________

____

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: CCB.Med@vermont.gov
- Receipt: A email will be sent by the MCP 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.

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Cannabis Control Board

Registered Caregiver Designation (OPTIONAL)

Instructions: ***These pages only need to be completed if the patient applicant wants to designate a caregiver. The next 2 pages must be completed by the person applying as the caregiver***. *This section is **not** to be completed by the patient.* A registered caregiver may assist one registered patient with cultivating cannabis or obtaining cannabis 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 Vermont Medical Cannabis Program. 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: ________)

First Name: ______________________________ M.I. ______ Last Name: ___________________________________

E-mail address: ____ Date of Birth: __________________

Physical Address: ____ Apt./Unit/Suite: __________________

City, State, Zip: ____

Mailing Address (if different than physical): ________________________________ Apt./Unit/Suite: __________________

City, State, Zip: ____

Maiden/Alias Name(s): ____________________________________Telephone Number: ________________________

Gender: ______________ Eye Color: _____________ Weight: __________lbs. Height: ______ ft. ________ in.

Social Security Number: __________________________ Place of Birth: _____________________________________

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

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 Medical Cannabis Program (MCP) 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 MCP and your dispensary will have your information.)

OFFICE USE ONLY: PHOTO: Yes No Date: ________________ CHRC: Approved Denied Date: __________________

NOTES: ____

VERMONT

4.) **<u>Caregiver Photo Requirements</u>**

Instructions: <u>Initial</u> applicants ***<u>MUST</u>*** submit a digital photo. <u>Renewal</u> 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: CCB.Med@vermont.gov
- Receipt: An email will be sent by the MCP staff confirming acceptance of your photo.

A hard copy of a photo or a photo on a CD may be submitted if you are unable to email a photo.

5.) **<u>Registered Caregiver Release Form</u>**

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 MCP 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.

***Caregiver Applicant Signature*: ______________________________ ***Date:* ____________________

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Cannabis Control Board

HEALTH CARE PROFESSIONAL VERIFICATION 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. The three-month requirement shall not apply if:

(i) a patient has been diagnosed with a terminal illness, cancer, or acquired immune deficiency syndrome.
(ii) a patient is currently under hospice care.
(iii) a patient had been diagnosed with a debilitating medical condition in another state and has moved to Vermont within the past 3 months. The new health care professional must have completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.
(iv) a renewal patient changes health care professionals three months or less prior to renewing their registration, provided 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.
(v) a patient is referred by his or her health care professional to another health care professional who has completed advanced education and clinical training in specific debilitating medical conditions, and that health care professional conducts a full assessment of the patient's medical history and current medical condition, including a personal physical examination; or
(vi) a patient's debilitating medical condition is of recent or sudden onset.

"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.

An applicant without a "debilitating medical condition" is not eligible for a registry identification card.

State of Vermont
Medical Cannabis Program

Cannabis Control Board

HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant's health care professional and signed within the past 6 months. *The Medical Cannabis Program (MCP) will contact the health care professional completing this form to confirming the accuracy of the information.*

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)

First Name: ______________________ M.I. ______ Last Name: ______________________

Date of Birth: ______________________ Telephone Number: ______________________

2) HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

First Name: ______________________ M.I. ______ Last Name: ______________________

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* MCP*)*
☐ 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.

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 Medical Cannabis Program (MCP) 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 MCP 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 MCP 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 MCP receives this form, unless a written communication revoking this authorization, or a new authorization is received by the MCP. 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 MCP 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: ____________

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Cannabis Control Board

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 Medical Cannabis Program (MCP) to confirm applicants with PTSD are undergoing psychotherapy, or counseling with a Vermont licensed mental health care provider. The MCP 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 licensed in Vermont to practice medicine who specializes in the practice of psychiatry; a psychologist, a psychologist-doctorate, or a psychologist-master; a clinical social worker; or a clinical mental health counselor.

1. Patient Information

Last Name: ______________________________ First Name: __________________________ M.I. ____

Date of Birth: ______________________________ Telephone Number: _________________________

2. Mental Health Care Provider Information

Last Name: ______________________________ First Name: __________________________ M.I. ____

Office Mailing Address: ____

City, State, Zip Code: ______________________________ Telephone Number: __________________

3. Vermont 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. Vermont License Number: ______________________________

4. Verification

I certify I am licensed in Vermont as a mental health care provider in good standing and provide psychotherapy and/or counseling to the patient identified on this form. I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate and that the facts stated above are accurate to the best of my knowledge and belief.

SIGNATURE: ____ **DATE:** _____________________

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OFFICE USE ONLY: Notes: ____

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