



**State of Vermont**  
**Medical Cannabis Program**  
89 Main Street  
Montpelier, Vermont 05620-7001  
[www.ecb.vermont.gov](http://www.ecb.vermont.gov)

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

Cannabis Control Board

## **PATIENT REGISTRATION APPLICATION**

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

### ***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?
- 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 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.***)
- 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 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?
- 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 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 3 and 4?

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

Cannabis Control Board  
Medical Cannabis Program  
89 Main Street  
Montpelier, VT 05620-7001



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

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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: \_\_\_\_\_



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](mailto: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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**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.)

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**OFFICE USE ONLY:** PHOTO: Yes No Date: \_\_\_\_\_ CHRC: Approved Denied Date: \_\_\_\_\_

NOTES: \_\_\_\_\_



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
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- Attach your photo
- Email Address: [CCB.Med@vermont.gov](mailto: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.) **\*\*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 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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