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

*Cannabis Control Board*

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

# CAREGIVER APPLICATION

## *APPLICATION CHECK SHEET*

*Carefully review* the 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 from receipt**.**

1) ☐ Have you completed page 1 and signed 2?

2) ☐ Have you submitted a photo following the instructions on page 2?
(*Renewal applicants are NOT required to submit a photo.)*

3) ☐ Have you enclosed a check or money order for the $50 non-refundable fee payable to the Vermont Medical Cannabis Program? ***(If the patient is under the age of 18, the fee is not required for the first caregiver application received.)***

4) ☐ Verify the check or money order has been signed, dated, and the correct amount is written out.

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

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

VERMONT

# CAREGIVER REGISTRATION APPLICATION

**Instructions:** Carefully review all pages. *Legibly* complete ALL sections, unless labeled optional. Incomplete applications will be returned. A registered caregiver may assist one registered patient with cultivating cannabis and obtaining cannabis from the patient's designated dispensary. Registered caregivers may accompany his or her patient to an appointment at the dispensary and be present in the dispensing room. **All caregiver registration applications must specify a registered patient and be submitted with a non-refundable $50 check or money order payable to the Vermont Medical Cannabis Program.** *Note:* A registered patient under the age of 18 may have 2 designated caregivers. Each caregiver must complete a Registered Caregiver Application, the fee is not required for the first caregiver application received for a patient under the age of 18. Contact the MCP with any questions.

***ALL SECTIONS OF THIS FORM MUST BE COMPLETED***

**1) **REGISTERED PATIENT INFORMATION**** (Specify the patient designating you as their registered caregiver)

First Name _____ M.I. ____ Last Name _____ Date of Birth: _____

**2) **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: Select Item Eye Color: _____ Weight: _____lbs. Height: _____ ft. _____ in.

Social Security Number: _____ Place of Birth: _____

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

**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 patient's designated dispensary? ☐ ***Yes*** ☐ ***No***

(Checking ***Yes*** will enable you to receive **deliveries** 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**: Funds #: _____ Amount: $_____ Funds Date: _____ Photo: ***Yes*** ***No*** Date: _____

CHRC: Approved Denied Initials: _____ Date: _____ NOTES: _____

**4.) **Caregiver Photo Requirements****

**Instructions:** Initial applicants ***MUST*** submit a digital photo. Renewal applicants must submit an updated photo, if your appearance has significantly changed.

**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 (AKA a selfie. No hats or 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: 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.) **Criminal Record Release Form and Signature****

***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.

***Caregiver Applicant Signature*: _____ ***Date:* _____

***Patient must complete this section***

I hereby acknowledge it is my sole preference, as a registered patient, to designate this applicant as my registered caregiver to provide me assistance with the use of cannabis for symptom relief. I further acknowledge and agree this decision was not made under duress.

***Patient Signature REQUIRED***: _____ ***ID#:*** _____

***PRINT Patient Name:*** _____ ***Date:*** _____

*(If the patient is **under 18 years old** or has a **court appointed guardian** the parent or guardian must complete this section.)*

Parent or Guardian Signature: _____

First Name: _____ M.I. _____ Last Name: _____

Mailing Address: _____

City, State, Zip: _____