State of Vermont
Medical Cannabis Program
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Cannabis Control Board

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 a medical 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. 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: _____________ Eye Color: ____________ Weight: _________lbs. Height: _____ ft. _______ in.

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

3) **DISPENSARY COMMUNICATION & DELIVERY** (This authorization may be withdrawn at any time.)

May the Medical Cannabis Program (MCP) provide your address, phone number, and email (if applicable) to the medical 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.)

OFFICE USE ONLY: Funds #: ______________________ Amount: $__________ Funds Date: ________________ Photo: ***Yes*** ***No***

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.) ***SIGNATURE REQUIRED***

I declare under pains and penalty of perjury that the information provided on this form is true and accurate.

***Caregiver Applicant Signature*: ____ ***Date:* ___________________

6) ***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: ____