State of Vermont
Medical Cannabis Program

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

Cannabis Control Board

PATIENT REGISTRATION APPLICATION

Instructions: Carefully review all pages. *Clearly and legibly* complete ALL sections, unless labeled optional. An application deemed incomplete will be returned for your completion. All patient applications ***must*** be submitted with a non-refundable $50 check or money order made payable to the Vermont Medical Cannabis Program.

****PATIENT INFORMATION****

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

Phone Number: __________________ E-mail address**:** ______________________________

Physical Address: ____

Apt./Unit/Suite: _______ City: ________________________ State: _______ Zip: __________

Mailing Address (if different than physical address): ____________________________________

Apt./Unit/Suite: _______ City: ________________________ State: _______ Zip: __________

Date of Birth: _________ Gender: ________ Eye Color: _______ Weight: _____lbs. Height: ___ ft. ____ in.

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

****DISPENSARY COMMUNICATION & DELIVERY**** (This authorization may be withdrawn at any time.)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 dispensaries? ☐ ***Yes**** ☐ ***No***

**YES,* must be checked if you wish to receive delivery services from medical dispensaries. The MCP will *ONLY* provide your contact information to the medical dispensaries.

****PHOTO REQUIREMENT**** *(ALL APPLICANTS ARE REQUIRED TO SUBMIT A DIGITAL PHOTO)*

Photos 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.
- DO NOT submit a photo of a photo ***(please just take a photo of yourself or have someone take a photo of you)***.

How To Submit a Photo:

- Send an email (with photo attached) from your computer, cell phone, or mobile device to CCB.MED@Vermont.gov
- Subject Line: The applicant's full name (first and last) and date of birth.
- Confirmation: MCP staff will send an email notification confirming receipt and acceptance of your photo.

****Patient Signature REQUIRED**** (Applications WILL BE RETURNED if this section is blank)

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

*****Patient Applicant Signature*:** ______________________________ *****Date***: ___________

REQUIRED FOR PATIENTS UNDER 18 YEARS OLD
OF HAVE A GUARDIAN OR A POWER OF ATTORNEY

**Proof of guardianship or power of attorney must be submitted to the Medical Cannabis Program unless documentation is already on file.

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*:** ____ ***Date**:* _________________

PRINT NAME: ____

Provide your contract information, if different from the patient: ____

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***MAIL COMPLETED APPLICATIONS TO:* **

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