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

Instructions: Please complete the required information below. **All** applications must be submitted with a non-refundable $50 check or money order made payable to the Vermont Medical Cannabis Program. If your application is incomplete or more information is required, the MCP will reach out to you. Complete applications will be processed in the order they were received, and a card will be mailed.

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

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

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

CAREGIVER INFORMATION

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

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

E-mail Address: _____ Date of Birth: _____

Gender: _____ Eye Color: _____ Weight: _____lbs. Height: _____ ft. _____ in.

*V*alid Vermont Driver's License or Non-Driver ID #: _____

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: _____

DISPENSARY COMMUNICATION & DELIVERY (This authorization may be withdrawn at any time.)

May the Medical Cannabis Program (MCP) provide your address, phone number, and email to the medical dispensaries?

YES, must be checked if you wish to receive delivery services from a medical dispensary.

☐ ***Yes*** ☐ ***No***

OFFICE USE ONLY: Funds #: _____ Amount: $_____ Funds Date: _____
NOTES: _____

PHOTO REQUIREMENT *(All initial and renewal applications require a digital photo)*

How To Submit a Photo:

- **Photos must be clear, in color and reflect your current appearance.**
  - 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.

SIGNATURE REQUIRED

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

Caregiver 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: _____

MAIL COMPLETED APPLICATIONS TO:

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