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

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

Cannabis Control Board

PATIENT 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

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

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

Phone Number: _____ E-mail Address: _____

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

Date of Birth: _____ *Valid Vermont* Driver's License or Non-Driver ID #: _____

Physical Address: _____

Apt./Unit/Suite: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different than physical address): _____

Apt./Unit/Suite: _____ City: _____ State: _____ Zip: _____

DISPENSARY COMMUNICATION & DELIVERY (This authorization may be withdrawn at any time.)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

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.

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

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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 Signature: _____ ***Date***: _____

REQUIRED FOR PATIENTS UNDER 18 YEARS OLD

OR 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: _____

_____

MAIL COMPLETED APPLICATIONS TO:

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