



**State of Vermont**  
**Medical Cannabis Program**  
89 Main Street  
Montpelier, Vermont 05620-7001  
[www.ccb.vermont.gov](http://www.ccb.vermont.gov)

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

*Cannabis Control Board*

## Dear CCB Caregivers:

### What is needed from you for a completed Caregiver Application?

- Active patient in Medical Card Registry
- Caregiver Application: Completed, signed, and dated
- \$50 non-refundable fee: Check or money order made out to the Vermont Medical Cannabis Program
- Photo: (Simply take a color photo of yourself. Photos of photos or a photo of your driver's license will not be accepted) -Emailed to [ccb.med@vermont.gov](mailto:ccb.med@vermont.gov) with first name, last name, and date of birth

### What the CCB requires internally to approve a Caregiver?

- Vermont Criminal Conviction Background Check
- Vulnerable Adult Abuse, neglect, and exploitation registry
- Child Protection Registry Check

**Once we have received the results from these background checks we can begin to process the application. Please be aware these background checks can take up to 10 days to complete.**

If you have any questions we can be reached by phone at (802)- 828-1010 ext. 2 or by email at [ccb.med@vermont.gov](mailto:ccb.med@vermont.gov).

### **Dispensary Locations:**

**CeresMED** – (844) 283-9333  
2 Green Tree Drive  
South Burlington, VT 05403  
<https://ceresvt.com/pages/vermont-medical-dispensaries>

**CeresMED South** – (844) 789-9333  
942 Putney Road  
Brattleboro, VT 05301  
<https://ceresvt.com/pages/vermont-medical-dispensaries>

**Vermont Patients Alliance** - (802) 225-6786  
188 River Street  
Montpelier, VT 05602  
<https://www.vpavt.com/>

**Grassroots Vermont** - (802) 465-8081  
84 Lovers Lane  
Brandon, VT 05733  
<https://www.grassrootsvermont.com>



**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: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**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.

Valid 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: \_\_\_\_\_

Last 4 digits of social security: \_\_\_\_\_ Place of Birth (City, State, Country): \_\_\_\_\_

**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

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**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. Please do not send a copy of your driver's license.**
  - Send an email (with photo attached) from your computer, cell phone, or mobile device to [CCB.MED@Vermont.gov](mailto: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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Medical Cannabis Program  
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