Cannabis Control Board

Disability Accommodation Policy

Policy

The Vermont Cannabis Control Board (CCB) complies with applicable provisions of Title II of the *Americans with Disabilities Act* (ADA) by extending reasonable accommodations to qualified applicants and licensees with disabilities whose need for the same is verified by a suitable provider. Reasonable accommodations may include the provision of auxiliary aids and services.

Laws and rules governing cannabis establishment licensure serve to protect the public and the integrity of the regulated cannabis and cannabis product supply. An accommodation may assist an applicant or licensee in achieving and demonstrating compliance with requirements, but no accommodation may fundamentally alter licensing criteria or authorize non-compliant conduct.

The CCB can provide accommodations in respect to programs and activities the CCB administers. Requests for accommodation by a third-party should be directed to that party. The CCB will recognize third-party accommodations that comply with this policy.

Definitions

For the purposes of this policy, the following definitions apply:

1. *Disability* is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual (such as seeing, hearing, learning, reading, concentrating, or thinking) or a major bodily function (such as the neurological, endocrine, or digestive system). Mental impairment includes any mental or psychological disorder, such as organic brain syndrome, emotional or mental illness, and specific learning disabilities.
2. *Qualified applicant or licensee with a disability* means an individual who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.
3. *Auxiliary aids and services* include but are not limited to qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments; qualified readers, taped texts, or other effective methods of making visually delivered test

materials available to individuals with visual impairments; acquisition or modification of equipment or devices.

4. *Reasonable accommodation* means an adjustment or modification of the standard conditions, means, or proxies by which qualifications are assessed that ameliorates the impact of the applicant's disability.
5. *Suitable provider* means a licensed health care professional with a provider-patient relationship to the applicant, who has examined the applicant and become oriented to the applicant's condition, and who is qualified by training, education, experience, and scope of professional practice to opine on the nature, severity, and duration of any disability found, as well as the necessity and utility of requested accommodations.

Process

To request accommodation, a qualified applicant with a disability shall provide the CCB clear, credible, written documentation from a suitable provider or providers, sufficient to demonstrate:

1. that the applicant has a disability;
2. the nature, severity, and duration of that disability;
3. that a specific accommodation or accommodations would ameliorate the impact of the applicant's disability on the applicant's ability to demonstrate essential compliance requirements within the CCB's jurisdiction.

The Application for Disability Accommodation forms below are designed to facilitate the orderly provision of relevant information from applicants, licensees, and providers. Their use is strongly encouraged; however, the CCB will recognize requests in non-standard formats.

Submit forms and supporting documents to CCB.applications@vermont.gov. Persons unable to submit documents electronically may mail them to: Cannabis Control Board, 89 Main Street, 3rd Floor, Montpelier, VT 05620-7001.

Request for Accommodation

PART I: APPLICANT'S STATEMENT

Name: _____ **License Type & Tier:** _____

Address: _____

Telephone Number: _____ **Email Address:** _____ **Date of Birth:** _____

Seeking accommodation for: ☐**License Qualifying Criterion** * ☐**Operating or Participating**

**The CCB can provide accommodations only for qualifying criteria and public activities the agency administers. For example, a wheelchair user may request that mobility lanes be excluded from net canopy square footage; or a person with a speech impairment may obtain authorization to tell customers of the mandatory health warning by other means. However, an applicant seeking accommodation to achieve required certification or approval by a third-party, including another subdivision of government, must seek accommodation from that party.*

Specify the accommodation requested. Please cite any statute or rule implicated:

_____

_____

Description of disability and how it impacts ability to qualify or comply by conventional means:

_____

_____

Physician, Therapist, or Other Health Care Practitioner (list additional practitioners on a separate sheet of paper and attach to this form):

Name: _____ **Phone Number**: _____ **Years as Patient**: _____

Office Address: _____

If you previously have received accommodation(s) relative to the disabling condition, please list the accommodation(s) and entity that offered it: _____

RELEASE TO OBTAIN RECORDS (OPTIONAL)

To expedite evaluation of my request for reasonable accommodation, I authorize the practitioner(s) listed above to release to the Cannabis Control Board (CCB) any and all information in his or her possession about my disability described above. Information means all information in the possession of, or derived from, providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until canceled in writing by me. I understand that the CCB will use the information obtained by this authorization to determine eligibility for reasonable accommodation relative to State regulatory requirements. The information provided will be used by the CCB only for the purpose stated and will not be released for any other purpose unless by order of a court of competent jurisdiction. I understand that I may opt not to authorize release of all records and may instead supply documentation of my choosing.

☐I authorize the providers listed above to share information as the CCB may request. OR
☐I will arrange for the transmission of specific information from my provider to the CCB.

ATTESTATION

Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time

Signature:

Date:

Application for Disability Accommodation

PART II: PRACTITIONER S STATEMENT

Practitioner Name: _____ **Professional Title:** _____

Telephone Number: _____ **State License Number (if applicable):** _____

Office Address: _____

Patient'sName: _____

Patient's Address : _____

Date Patient First Consulted: _____ **Date Patient Last Seen:** _____

Diagnosis of Disability and Basis for Diagnosis: _____

Duration and Persistence of Condition: _____

Recommended Accommodation(s): _____

_____

CERTIFICATION

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by my patient. I also certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the individual named above, and that the above diagnosis and assessment of the accommodation request is my professional judgment. I understand that the Cannabis Control Board (CCB) may contact me (with the applicant's permission) to obtain further information if necessary, and that the CCB may obtain an independent assessment by another professional.

Practitioner's Signature: _____ **Date:** _____