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

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 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.

Dispensary Locations:

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

Hello, Hi
(802) 209-5958
46 Main Street Suite 102
Winooski, VT 05404
www.hellohivt.com

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

*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: _____

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***

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
  - 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:

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