State of Vermont
Marijuana Registry
45 State Drive
Waterbury, Vermont 05671-1300

[phone] 802-241-5115
[fax] 802-241-5230
[email] DPS.MJRegistry@vermont.gov

Department of Public Safety

REGISTERED PATIENT APPLICATION

Instructions: Carefully review the entire application. *Legibly* complete all sections labeled **"REQUIRED"** and sections labeled **"OPTIONAL",** if they apply to you. Applications submitted without completing *all* sections labeled **"REQUIRED"** may be returned. Initial applications *must* be notarized and submitted with a photo of the applicant. The photo must be sent via email to DPS.MJRegistry@vermont.gov prior to mailing in your application or on a CD with your application. Renewal applications are *not required* to be notarized or submitted with a photo. All patient applications must be submitted with a $50 check or money order made payable to the Department of Public Safety.

COMPLETE ALL SECTIONS OF THIS FORM LABELED REQUIRED

1.) CONTACT INFORMATION (REQUIRED)

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

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

Mailing Address: _____

City, State, Zip: _____

Physical Address (if different than mailing): _____

City, State, Zip: _____ Telephone Number: _____

E-mail address **(OPTIONAL):** _____

2.) IDENTIFICATION INFORMATION (REQUIRED)

(Circle One) MALE FEMALE

Date of Birth: _____ Eye Color: _____ Weight: _____lbs. Height: _____ ft. _____ in.

VALID VT Driver's License or Non-Driver ID #: _____

3.) PROCUREMENT SELECTION (REQUIRED, check only one)

(***Please note***: Cultivators *do not* designate a dispensary. Patients who elect to cultivate, may not purchase marijuana from a dispensary. Patients who designate a dispensary for purchasing marijuana, *cannot* cultivate marijuana or change dispensaries for 30 days.)

☐ Champlain Valley Dispensary (Burlington)

☐ Grassroots Vermont (Brandon)

☐ Southern Vermont Wellness (Brattleboro)

☐ Vermont Patients Alliance (Montpelier)

☐ Cultivate (Provide cultivation address and location within building): _____

_____

4.) DISPENSARY COMMUNICATION (OPTIONAL)

☐ Checking this box will allow the Vermont Marijuana Registry (VMR) to provide your contact information to your designated dispensary. Dispensaries are required to treat patient information as confidential. This authorization may be withdrawn at any time.

OFFICE USE ONLY: M.O. /CK #:_____ Amount: $_____ M.O. /CK Date: _____
SAVED PHOTO: Yes _____ No _____ Date: _____ HCPF VERIFIED: Yes _____ No _____ Date: _____
NOTES: _____

_____

Registered Patient Acknowledgements (REQUIRED)

Instructions: ***ALL*** statements below ***MUST*** be ***INITIALED*** signifying you have read and understand the information.

_____ I understand if my application is approved, my registration is valid for *one year* and marijuana may *only* be used for symptom relief.

_____ I understand it is my responsibility to renew annually with the VMR by submitting the *required* completed application with a non-refundable $50 fee to the VMR 30 days before my expiration date to prevent a lapse in status but no more than 90 days before my expiration date. Additionally, I understand that I must report a lost or stolen registry identification card to the VMR within 10 business days.

_____ I understand the use of marijuana is *prohibited*; on the property of a registered dispensary; in any public place, while operating a motor vehicle, boat, or any other vehicle propelled or drawn by power other than muscular power; in a workplace; operating heavy machinery or handling a dangerous instrumentality; or in a manner that endangers the health or well-being of another person.

_____ I understand if my application is denied the decision may be appealed. The Notice of Appeal *must* be submitted within 7 days and the review is limited to the information submitted with this application and consultation with my Health Care Professional.

_____ I understand if my application is approved and I elect to cultivate, marijuana plants *must* be grown in the single secure indoor facility identified on this application. A secure indoor facility means a building or room equipped with locks or other security devices that *only* permits access to me (and my registered caregiver(s), if applicable).

_____ I understand if my application is approved and I elect to cultivate in my identified single secure indoor facility, I may possess *no more* than 2 mature plants, 7 immature plants, and 2 ounces of usable marijuana.

_____ I understand if my application is approved and I elect to cultivate, I *may not* purchase usable marijuana from a dispensary but may purchase clones or seeds to assist in the cultivation process.

_____ I understand if my application is approved and I designate a dispensary, I may possess no more than 2 ounces of usable marijuana and *may not* cultivate marijuana. Additionally, I may only change my designated dispensary once every 30 days.

_____ I understand if my application is approved, marijuana *may not* be transported in public, including in a motor vehicle except in a locked container; this includes transporting marijuana from a dispensary.

_____ I understand a Law Enforcement Officer is *not* required to return marijuana or paraphernalia after seizure. Additionally, Law Enforcement that discovers marijuana cultivation occurring in a manner other than permitted, by 18 V.S.A. Chapter 86 or the Rules governing the VMR, are *not* required to return seized marijuana or paraphernalia and criminal penalties may apply.

_____ I have instructed my registered caregiver(s) or next of kin, in the event of my death, the VMR *must* be notified within 72 hours and arrange for disposal of any and all marijuana and/or marijuana plants.

_____ I understand that providing false information on this application or to Law Enforcement, may result in imprisonment, a fine, or both. This penalty may be in addition to other penalties that may apply.

_____ I understand the possession of marijuana remains a violation of Federal Law and Vermont Law *does not* provide protections against Federal Law violations.

_____ I understand that my health insurer is not required to cover or reimburse the cost of marijuana for symptom relief.

THE APPROPRIATE SECTION OF THIS PAGE ***MUST*** BE COMPLETED

(Please do not cut this page)

INITIAL *PATIENT APPLICANTS MUST COMPLETE THIS SECTION*

NOTARY REQUIRED

I swear under oath that I have read and understand the Registered Patient Acknowledgements and that by my signature I acknowledge that the information I have provided in this application is true and accurate. I personally appeared and identified myself before the Notary Public certifying this document.

Patient Applicant Signature: _____ *Date*: _____

Subscribed and duly sworn before me on _____ _____, 20_____.

Notary Public Signature: _____ *Commission exp. date*: _____ _____, 20____.
(month) (day) (year)

RENEWAL *PATIENT APPLICANTS MUST COMPLETE THIS SECTION*

SIGNATURE REQUIRED

I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate. I certify that I have read and understand the Registered Patient Acknowledgements.

Patient Applicant Signature: _____ *Date*: _____

THIS SECTION IS ONLY REQUIRED FOR PATIENTS ***UNDER 18 YEARS OLD***

Or if the patient has a court appointed guardian or durable power of attorney*:*

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: _____

PRINT LEGAL NAME Last: _____ First: _____ M.I. _____

Mailing Address: _____

City, State, Zip _____

If the patient applicant has a court *appointed a guardian* or durable power of attorney, please attach proof of guardianship or power of attorney.

Registered Caregiver Designation (OPTIONAL)

Instructions: ***If the patient applicant wants to designate a caregiver, the following 3 pages must be completed by the person chosen by the patient***. *This section is not to be completed by the patient applicant.* If the patient's preference is to not designate a caregiver at this time the following 3 pages are not required to be completed or submitted. A caregiver *cannot* be a currently registered patient or caregiver. A registered caregiver may assist a registered patient with cultivation or obtaining marijuana from the patient's designated dispensary. **If this caregiver section is completed, the caregiver applicant must submit a $50 check or money order made payable to the Department of Public Safety.** Initial applications must be submitted with a photo of the applicant on a CD submitted with the application or via email to DPS.MJRegistry@vermont.gov prior mailing the application. Renewal applications are not required to submit a photo.

Note: Patient applicants under the age of 18 may register 2 caregivers; each caregiver must complete this section or complete the "Registered Caregiver Application".

1.) CAREGIVER APPLICANT INFORMATION

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

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

Maiden or Alias Name(s): _____

Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

Physical Address (if different than mailing): _____

City, State, Zip: _____ Social Security Number: _____

Place of Birth (City/Town): _____ State: _____ Country: _____

E-mail address: _____

VALID VT Driver's License or Non-Driver ID #: _____

In addition to Vermont, I have resided or been employed in the following states (List all that apply): _____

_____

2.) IDENTIFICATION INFORMATION

(Circle One) MALE FEMALE

Date of Birth: _____ Eye Color: _____ Weight: _____lbs. Height: _____ ft. _____ in.

3.) DISPENSARY COMMUNICATION (OPTIONAL)

☐ Checking this box will allow the Vermont Marijuana Registry (VMR) to provide your contact information to your patient's designated dispensary. The information received by the dispensary is confidential. This authorization may be withdrawn at any time.

OFFICE USE ONLY: M.O. /CK #:_____ Amount: $_____ M.O. /CK Date: _____
SAVED PHOTO: Yes _____ No _____ Date: _____ CHRC: Approved _____ Denied _____ Date: _____
NOTES: _____

_____

Registered Caregiver Acknowledgements

Instructions: ***ALL*** statements below ***MUST*** be ***INITIALED*** signifying you have read and understand the information.

_____ I understand a registered caregiver can *only* care for **ONE** registered patient and must be at least 21 years old.

_____ I understand that applying as a caregiver indicates undertaking responsibility for managing my registered patient's well-being with respect to the use of marijuana for symptom relief. This may include assisting my registered patient with cultivation or obtaining marijuana from their designated dispensary.

_____ I understand if my application is approved, my registration is valid for *one year*.

_____ I understand it is my responsibility to renew annually with the VMR by submitting the required completed application with a non-refundable $50 fee to the VMR 30 days before my expiration date to prevent a lapse in status but no more than 90 days before my expiration date. Additionally, I understand that I must report a lost or stolen registry identification card to the VMR within 10 business days.

_____ I understand that I must consent to a criminal record check conducted by the VMR. The criminal record check includes Vermont, out-of-state, and FBI criminal records.

_____ I understand that if my application is denied due to a criminal conviction(s) a copy of the record will be sent for review. The accuracy and completeness of the criminal record may be appealed in writing within 7 days.

_____ I understand that if my application is approved and my registered patient elects to cultivate, marijuana plants must be grown in a single secure indoor facility. A secure indoor facility means a building or room equipped with locks or other security devices that *only* allows access to me and my registered patient.

_____ I understand if my registered patient elects to cultivate the possession limit, between me and my registered patient, is *no more* than 2 ounces of usable marijuana, 2 mature marijuana plants and 7 immature marijuana plants.

_____ I understand if my registered patient elects to cultivate, we *may not* purchase usable marijuana but may purchase clones or seeds from a dispensary.

_____ I understand if my registered patient designates a dispensary, *no more* than 2 ounces of usable marijuana may collectively be in possession by me and my registered patient at any time and we *may not* cultivate marijuana plants.

_____ I understand that a registered caregiver is *not* authorized to use marijuana and my use of marijuana can be subject to criminal penalties.

_____ I understand marijuana *may not* be transported in public, including in a motor vehicle except in a locked container; this includes transporting marijuana from a dispensary.

_____ I understand in the event of the death of my registered patient, I *must* notify the VMR within 72 hours and arrange for the disposal of any marijuana or marijuana plants.

_____ I understand that a Law Enforcement Officer is *not* required to return marijuana or paraphernalia after seizure. Additionally, Law Enforcement that discovers marijuana cultivation occurring in a manner other than permitted, by the Rules governing the Registry, are *not* required to return seized marijuana or paraphernalia.

_____ I understand that providing false information on this application or to Law Enforcement, may result in imprisonment, a fine, or both. This penalty may be in addition to other penalties that may apply.

_____ I understand that the possession and distribution of marijuana remains a violation of Federal Law and Vermont Law does *not* provide protection against a violation of Federal Law.

Registered Caregiver Release Form

I hereby acknowledge and consent to a review of any criminal records obtained from the Vermont Crime Information Center, out-of-state law enforcement agencies, and the Federal Bureau of Investigation. I understand that the results will be made available to the VMR for determining my eligibility as a registered caregiver, as specified in Title 18 V.S.A. Chapter 86.

Additionally, I declare under pains and penalty of perjury that the information provided on this form is true and accurate and that I have read and understood the Registered Caregiver Acknowledgements.

Caregiver Applicant Signature ***REQUIRED***: _____ Date: _____

APPLICATION CHECK SHEET

Carefully review the appropriate check list below prior to submitting your application to the VMR, incomplete applications may be returned and delay processing. The VMR will process complete applications within 30 days from receipt.

INITIAL APPLICANTS

☐ 1) Have sections 1 thru 3 been completed on page 1?

☐ 2) On page 1, under section 3, has only one box been checked?

☐ 3) If you selected to "Cultivate" on page 1, did you provide the cultivation address and location within building?

☐ 4) Have you initialed ***all*** the Acknowledgements on page 2?

☐ 5) Has the application been notarized and dated on page 3?

☐ 6) Have you enclosed a completed Health Care Professional Verification Form?

☐ 7) Have you enclosed a check or money order for the appropriate fee payable to the Department of Public Safety?
*(**Fees**: $50 Patient application and $50 for each Caregiver application*)

☐ 8) Verify the check or money order has been signed, dated, and the correct amount written out.

☐ 9) Have you enclosed a CD with a **color** photo or emailed a **color** photo of yourself to DPS.MJRegistry@vermont.gov?
a.) Photos submitted via *email* must be sent prior mailing this application and include your name and date of birth.
b.) Photos submitted on a *CD* must be sent with this application and have your name and date of birth on the CD.
*(*Note: The color photo must be of the applicant(s) upper body. Copies of photos will NOT be accepted.)*

☐ 10) If designating a caregiver, have sections 1 and 2 on page 4 been completed by the caregiver applicant?

☐ 11) If designating a caregiver, have pages 5 and 6 been completed by the caregiver applicant?
Note: Caregiver applicants must submit a photo and fee (see 7 thru 9 above.)

RENEWAL APPLICANTS

☐ 1) Have sections 1 thru 3 been completed on page 1?

☐ 2) On page 1, under section 3, has only one box been checked?

☐ 3) If you selected to "Cultivate" on page 1, did you provide the cultivation address and location within building?

☐ 4) Have you initialed ***all*** the Acknowledgements on page 2?

☐ 5) Has the application been signed and dated on page 3?

☐ 6) Have you enclosed a completed Health Care Professional Verification Form?

☐ 7) Have you enclosed a check or money order for the appropriate fee payable to the Department of Public Safety?
*(**Fees**: $50 Patient application and $50 for each Caregiver application*)

☐ 8) Verify the check or money order has been signed, dated, and the correct amount written out.

☐ 9) Has your appearance significantly changed? If yes, see #9 of the "Initial applicants" section above.

☐ 10) If designating a caregiver, have sections 1 and 2 on page 4 been completed by the caregiver applicant?

☐ 11) If designating a caregiver, have pages 5 and 6 been completed by the caregiver applicant?

ALL COMPLETED APPLICATIONS MUST BE MAILED TO:

Department of Public Safety
Marijuana Registry
45 State Drive
Waterbury, VT 05671-1300