State of Vermont
Marijuana Registry
45 State Drive
Waterbury, Vermont 05671-1300
www.dps.vermont.gov

Department of Public Safety

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

PATIENT REGISTRATION PACKET

(Includes Patient application, Caregiver application, and Health Care Professional Verification Form)

APPLICATION CHECK SHEET

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

INITIAL APPLICANTS

☐ 1) Have you completed pages 1-3?

☐ 2) Have you submitted a photo following the instructions on page 3?

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

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

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

☐ 8) If designating a caregiver, has the person applying to be a caregiver completed pages 4-6?

RENEWAL APPLICANTS

☐ 1) Have you completed pages 1-3?

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

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

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

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

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

☐ 7) If designating a caregiver, has the person applying to be a caregiver completed pages 4-6?

MAIL COMPLETED APPLICATIONS TO:

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

PATIENT REGISTRATION PACKET

(Includes Patient application, Caregiver application, and Health Care Professional Verification Form)

Instructions: Carefully review all pages. *Clearly* complete ALL sections, unless labeled optional. Incomplete applications will be returned for completion. All patient applications ***must*** be submitted with a non-refundable $50 check or money order made payable to the Department of Public Safety.

1.) **PATIENT INFORMATION**

Application Type (check one): ☐ 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):** _____

Gender (circle one): *MALE* *FEMALE* Eye Color: _____ Weight: _____lbs. Height: ___ ft. _____ in.

Date of Birth: _____ ****VALID VERMONT*** Driver's License or Non-Driver ID #: _____

2.) **DISPENSARY DESIGNATION** (Select only **ONE** dispensary)

☐ Champlain Valley Dispensary (Burlington)
☐ Grassroots Vermont (Brandon)
☐ Southern Vermont Wellness (Brattleboro)
☐ Vermont Patients Alliance (Montpelier)

3.) **DISPENSARY COMMUNICATION & DELIVERY** (*Dispensaries are **REQUIRED** to maintain **ALL** patient and caregiver information as confidential in conformity with HIPAA*. This authorization may be withdrawn at any time.)

May the Vermont Marijuana Registry (VMR) provide your address, phone number, and email (if applicable) to your designated dispensary? ☐ ***Yes*** ☐ ***No***

(By checking ***Yes*** you will be eligible to receive **delivery** and your dispensary will be able to contact you about your appointment(s), if needed. *ONLY* the VMR and your dispensary will have your information.)

4.) ** CULTIVATION**

Do you plan on cultivating marijuana in the next 12 months? ☐ ***Yes*** ☐ ***No***

If you selected ***Yes***, the section below **MUST** be completed.

Secure Indoor Facility Information:

Physical address (where marijuana will be cultivated): _____

Location within building: _____

OFFICE USE ONLY: Funds #: _____ Amount: $_____ Funds Date: _____ Photo: ***Yes*** ***No*** Date: _____

HCP VERIFIED: ***Yes*** ***No*** Date: _____ Approved: ☐ Denied: ☐ On: _____ Initials: _____

NOTES: _____

Instructions: Read ***ALL*** the statements below. Once you have read all the statements, ***initial*** each statement signifying you have read and understand the information. If you do not understand any of the statements below, contact the VMR**.**

5.) **Patient Acknowledgements**

_____ 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.

_____ I understand a lost or stolen registry identification card *MUST* be reported 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 motorized vehicle; in a workplace; operating heavy machinery or handling a dangerous instrumentality; or that endangers the health or well-being of another person.

_____ I understand if my application is denied the decision may be appealed within 7 days and is reviewed based on the information submitted with this application and consultation with my Health Care Professional.

_____ I understand the amount of marijuana a registered patient and their caregiver ***collectively*** may possess is *no more than* 2 mature marijuana plants, 7 immature plants, and 2 ounces of usable marijuana at the same time.

_____ I understand if my application is approved and want 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 want to cultivate, I *MUST* identify a single secure indoor facility on this application.

_____ I understand if my application is approved, I may purchase marijuana and marijuana products, including seeds and clones from my designated dispensary.

_____ I understand if my application is approved, I *MUST* present my valid registry identification card to dispensary personnel at an appointment and at the time of delivery.

_____ I understand if my application is approved, I may only change my designated dispensary once every 30 days.

_____ I understand if my application is approved, marijuana *MUST* be transported in a locked container in public and when leaving 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 Vermont law or the Rules governing the VMR, they are *not* required to return seized marijuana or paraphernalia and civil or criminal penalties may apply.

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

_____ I understand providing false information on this application or to Law Enforcement may result in criminal penalties.

_____ I understand the possession and cultivation of marijuana remains a violation of Federal Law.

_____ I understand Vermont Law *does not* provide protections against Federal Law violations and does not apply to conduct that occurs outside of the State of Vermont.

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

6.) **Patient Photo Requirements**

Instructions: Initial applicants ***MUST*** submit a digital photo. Renewal applicants, if your appearance has significantly changed, an updated digital photo must be submitted.

Your photo must be:

- In color;
- Reflect your current appearance (taken within the last 6 months);
- A clear image of ONLY you (not blurry, grainy, or fuzzy);
- Full face-and-shoulder shot, squarely facing the camera (no sunglasses);

Additional Tips

- Do not scan your driver's license or another photo ID. The scanned image will not be of high enough quality to meet the requirements.
- Do not submit a photo of a photo ***(just take a photo of yourself)***.

Submitting a Photo – To submit a photo, send an email from your computer, cell phone, or mobile device with the following information:

- Subject Line: Your first and last name
- Include your date of birth with your first and last name in the body of the email.
- Attach your photo
- Email Address: DPS.MJRegistry@vermont.gov
- Receipt: A email will be sent by the VMR staff confirming acceptance of your photo.

If you are unable to email a photo, a photo may be submitted on a CD.

7.) **Patient Signature**

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*: _____

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, if not previously submitted.

Registered Caregiver Designation (OPTIONAL)

Instructions: ***If the patient applicant wants to designate a caregiver, the following 3 pages must be completed by the person the patient has selected***. *This section is not to be completed by the patient.* A registered caregiver may assist one registered patient with cultivation or obtaining marijuana from the patient's designated dispensary. **All caregiver applications must be submitted with a $50 fee payable to the Department of Public Safety. This fee is in addition to the fee for the patient application.**

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**

Application Type (check one): ☐ 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: _____

Gender (circle one): *MALE* *FEMALE* Eye Color: _____ Weight: _____lbs. Height: ___ ft. _____ in.

Date of Birth: _____ ****VALID VERMONT*** 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.) **DISPENSARY COMMUNICATION & DELIVERY** (*Dispensaries are **REQUIRED** to maintain **ALL** patient and caregiver information as confidential in conformity with HIPAA*. This authorization may be withdrawn at any time.)

May the Vermont Marijuana Registry (VMR) provide your address, phone number, and email (if applicable) to your patient's designated dispensary? ☐ ***Yes*** ☐ ***No***

(By checking ***Yes*** you will be eligible to receive **delivery** for your patient and the dispensary will be able to contact you about appointment(s), if needed. *ONLY* the VMR and your dispensary will have your information.)

OFFICE USE ONLY: M.O./CK #: _____ Amount: $_____ M.O. /CK Date: _____

PHOTO: Yes ☐ No ☐ Date: _____ CHRC: Approved ☐ Denied ☐ Date: _____ NOTES: _____

_____

Instructions: Read ***ALL*** the statements below. Once you have read all the statements, ***initial*** each statement signifying you have read and understand the information. If you do not understand any of the statements below, contact the VMR**.**

3.) **Caregiver Acknowledgements**

_____ 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.

_____ I understand a lost or stolen registry identification card *MUST* be reported 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 to me 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 the amount of marijuana a registered patient and their caregiver ***collectively*** may possess is *no more than* 2 mature marijuana plants, 7 immature plants, and 2 ounces of usable marijuana at the same time.

_____ 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 if my application is approved, marijuana *MUST* be transported in a locked container in public and when leaving a dispensary.

_____ I understand if my application is approved, I *MUST* present my valid registry identification card to dispensary personnel at an appointment and at the time of delivery.

_____ 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 Vermont law or the Rules governing the VMR, they are *not* required to return seized marijuana or paraphernalia and civil or criminal penalties may apply.

_____ I understand providing false information on this application or to Law Enforcement, may result in criminal penalties.

_____ I understand Vermont Law *does not* provide protections against Federal Law violations and does not apply to conduct that occurs outside of the State of Vermont.

4.) **<u>Caregiver Photo Requirements</u>**

Instructions: Initial applicants ***<u>MUST</u>*** submit a digital photo. Renewal applicants, if your appearance has significantly changed, an updated digital photo must be submitted.

Your photo must be:

- In color;
- Reflect your current appearance (taken within the last 6 months);
- A clear image of ONLY you (not blurry, grainy, or fuzzy);
- Full face-and-shoulder shot, squarely facing the camera (no sunglasses);

Additional Tips

- Do not scan your driver's license or another photo ID. The scanned image will not be of high enough quality to meet the requirements.
- Do not submit a photo of a photo ***(just take a photo of yourself)***.

Submitting a Photo – To submit a photo, send an email from your computer, cell phone, or mobile device with the following information:

- Subject Line: Your first and last name
- Include your date of birth with your first and last name in the body of the email.
- Attach your photo
- Email Address: DPS.MJRegistry@vermont.gov
- Receipt: A email will be sent by the VMR staff confirming acceptance of your photo.

If you are unable to email a photo, a photo may be submitted on a CD.

5.) **<u>Registered Caregiver Release Form</u>**

SIGNATURE REQUIRED

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*: _____ ***Date:* _____

HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant's health care professional and signed within the last 6 months. **This form must be completed and submitted with a Registered Patient Application.** The definitions below are provided to assist health care professionals when completing this form.

This verification form is NOT considered a prescription and the only purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined.

Notwithstanding any law to the contrary, a person who knowingly gives to any law enforcement officer false information to avoid arrest or prosecution, or to assist another in avoiding arrest or prosecution, shall be imprisoned for not more than one year or fined not more than $1,000.00 or both.

DEFINITIONS:

"Bona fide health care professional-patient relationship" means:

A treating or consulting relationship of not less than three months' duration, in the course of which a health care professional has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination.

"Debilitating medical condition" means:

A) Cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, glaucoma, Crohn's disease, Parkinson's disease or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms;

B) Post-traumatic stress disorder, provided the Department confirms the applicant is undergoing psychotherapy or counseling with a licensed mental health care provider; or

C) A disease or medical condition or its treatment that is chronic, debilitating and produces and one or more of the following intractable symptoms: cachexia or wasting syndrome, chronic pain, severe nausea, or seizures.

"Health care professional" means an individual who is:

A) Licensed to practice medicine under 26 V.S.A Chapter 23 or Chapter 33;
B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
C) Certified as a physician assistant under 26 V.S.A. Chapter 31; or
D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28.

This definition includes individuals who are professionally licensed under substantially equivalent provisions in New Hampshire, Massachusetts, or New York.

Patients diagnosed with PTSD are also required to submit a completed Mental Health Care Provider Form to the VMR.

An applicant without a "debilitating medical condition" is not eligible for a registry identification card.

HEALTH CARE PROFESSIONAL VERIFICATION FORM

The Vermont Marijuana Registry (VMR) will contact the health care professional completing this form to confirming the accuracy of the information.

***SECTIONS #1 – #6 MUST BE COMPLETED* and submitted with a completed Registered Patient Application**

This verification form is NOT considered a prescription and the only purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined.

1) PATIENT INFORMATION (Please print legibly)

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

Date of Birth: _____ Telephone Number: _____

2) HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

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

Office Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

3) HEALTH CARE PROFESSIONAL LICENSE INFORMATION:

License Number: _____ Issuing State (circle one): VT NH MA NY

4) LICENSURE CATEGORY

☐ Doctor of Medicine ☐ Osteopathic Physician ☐ Naturopathic Physician

☐ Physician Assistant ☐ Advanced Practice Registered Nurse

5) VERIFICATION OF A DEBILITATING MEDICAL CONDITION

(A) Does the patient applicant have a debilitating medical condition as defined on the Cover Sheet?

☐ No ☐ Yes *(if "Yes", Section B **MUST** be completed)*

(B) The patient applicant I am treating or consulting has been diagnosed with *(check all that apply)*:

☐ Acquired Immune Deficiency Syndrome ☐ Glaucoma

☐ Cancer ☐ Human Immunodeficiency Virus

☐ Crohn's Disease ☐ Multiple Sclerosis

☐ Parkinson's Disease

☐ *Post-Traumatic Stress Disorder *(*A Mental Health Care Provider Form is required to be completed and submitted to the VMR)*

☐ A disease or medical condition or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed in subdivision B. ***(**Subsections I and II MUST be completed**)***

I.) **Indicate specific diagnosis**: _____

II.) **Indicate specific symptom** (*circle all that apply*)**:** *cachexia chronic pain severe nausea seizures*

OFFICE USE ONLY – HCPF VERIFIED: Yes ☐ No ☐ Date: _____ NOTES: _____

6) BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP INFORMATION

(A) Have you completed a full assessment of the patient applicant's medical history and current medical condition, including a personal physical examination?

☐ Yes ☐ No

(B) Do you have a treating or consulting relationship with the patient application of at least three (3) months?

☐ Yes ☐ No

(C) Has the patient applicant been diagnosed with a terminal illness and/or currently under hospice care?

☐ Yes ☐ No

(D) Was the patient applicant diagnosed in another state or jurisdiction where they formally resided and moved to Vermont within the last three (3) months?

☐ Yes ☐ No

(E) Was the patient applicant diagnosed with the debilitating medical condition specified on the previous page within the last three (3) months?

☐ Yes (Date of diagnosis: _____/_____/_____) ☐ No

(F) Was the patient applicant referred to you by another health care professional because of your advanced education and clinical training specific to the debilitating medical condition specified on the previous page?

☐ Yes ☐ No

7) HEALTH CARE PROFESSIONAL SIGNATURE

I certify that:

(A) I am a health care professional;

A) Licensed to practice medicine under 26 V.S.A Chapter 23 or Chapter 33;
B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
C) Certified as a physician assistant under 26 V.S.A. Chapter 31; or
D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28; or,
E) Professional licensed under substantially equivalent provisions in NH, MA, or NY.

(B) I am in good standing with the state (VT, NH, MA, or NY) regulating my professional license, and that the facts stated on this Health Care Professional Verification Form are true and accurate to the best of my knowledge and belief.

(C) I understand, notwithstanding any law to the contrary, a person who knowingly provides false information on this application may be guilty of perjury and imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply.

This verification form is not considered a prescription and that the only purpose of this verification form is to confirm that the applicant patient has a debilitating medical condition.

Health Care Professional's Signature: _____ Date: _____

<u>This form must be completed and submitted with a Registered Patient Application.</u>

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS SECTION MUST BE COMPLETED BY THE PATIENT APPLICANT

I hereby authorize the health care professional named on this form to release my protected medical information to the Vermont Marijuana Registry (VMR) to verify and confirm the accuracy of the information contained within this form. I authorize the named health care professional to:

- Disclose the nature, symptoms, and duration of the medical condition identified on this form for the purpose of determining that it meets the legal definition of a debilitating medical condition on page 1 of this form;
- Disclose whether the named health care professional and I have a bona fide health care professional-patient relationship, as defined by law and on page 1 of this form;
- Confirm the accuracy of the information contained in this form.

I understand that any information released to the VMR will be used solely to confirm the accuracy of the information contained in this form. While the information will no longer be covered by the HIPAA Privacy Rule, Vermont law requires the VMR to keep all information confidential, except for the prosecution of false swearing. I understand this authorization is valid for one year from the date the VMR receives this form, unless a written communication revoking this authorization or a new authorization is received by the VMR. I understand that I have the right to revoke this authorization at any time by notifying both the health care professional named on this form and to the VMR in writing.

Patient Applicant Signature REQUIRED: _____ Date: _____

*If the patient applicant is **under the age of 18** or has a **court appointed guardian** the section below must be completed:*

Parent or Guardian Signature: _____ Date: _____