EFFECTIVE IMMEDIATELY WE WILL NO LONGER ACCEPT APPLICATIONS IN PERSON YOU MUST MAIL IN YOUR APPLICATION

Instructions

ALL PATIENTS:

- Must be a Rhode Island resident
- Complete and sign a "***Registration for Medical Marijuana Program – New Application***" (Patient Form)
- Pay an application fee (**Check or Money Order, Payable to RI General Treasurer**) Fee is seventy-five dollars ($75.00) **OR** for recipients of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) the fee is Ten dollars ($10.00) and you must submit satisfactory evidence, to the Department, of being a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI).
- Submit an "***Attending Practitioner Statement – New Application***" ("Practitioner Form") **MUST** be completed and signed by one of the following practitioner types: Physician licensed to practice in RI, MA or CT, a Physician Assistant, or Registered Nurse Practitioner licensed to practice in Rhode Island, for each patient to participate in the RI Medical Marijuana Program.
- May designate up to two (2) primary caregivers

MINOR PATIENTS (UNDER 18 YEARS OF AGE):

- In addition to requirements listed above, minor patients **MUST** designate a custodial parent or legal guardian as one of their primary caregivers. **Additionally**, a "***Declaration of Person Responsible for a Minor to Participate***" ("Minor Form") must be completed, signed and submitted along with the Patient Form as described above.

CAREGIVERS:

- Caregiver information is ALWAYS provided by the Patient.
- Background Check (BCI) for all caregivers. (To obtain BCI contact Attorney General's Office at (401) 274-4400) If your Caregiver lives in another state they must provide a BCI from the state where they live and also include one from Rhode Island.
- Each caregiver may be responsible for up to five (5) patients.
- Pay an application fee (**Check or Money Order, Payable to RI General Treasurer**) Fee is seventy-five dollars ($75.00) unless you are a qualifying caregiver who can submit satisfactory evidence, to the Department, of being a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). If you can submit such evidence then the fee is ten dollars ($10.00).

CHANGES OF INFORMATION (once registered) OR WITHDRAWAL FROM PROGRAM:

After you (and your caregiver(s)) receive your registration identification cards, you can change information by completing, signing and submitting a "***Medical Marijuana Program – Patient Information Change Request***" ("Change Form"). You can also use the same form to Withdraw from the program by checking box "D" "Withdraw from the Marijuana Program.

LOST CARD(s): There is a ten-dollar ($10.00) fee to reprint a new card.

Patient Check List without Caregiver

- ☐ Patient Form
- ☐ Practitioner Form - Send to your practitioner for completion
  - ☐ Application fee of **either** Seventy-Five Dollars ($75.00) - **or** Ten Dollars ($10.00) **and** a notarized copy of your Medicaid, SSI or SSDI Card. **Payment in the form of a Check or Money Order, Payable to RI General Treasurer**

Minor Patient Check List

- ☐ Patient Form
- ☐ Minor Form - To be completed by custodial parent or legal guardian
- ☐ Practitioner Form - Send to your practitioner for completion
- ☐ BCI (Background Check(s)) for caregiver(s) - (To obtain BCI contact Attorney General's Office at (401) 274-4400)
  - ☐ Application fee of **either** Seventy-Five Dollars ($75.00) **or** Ten Dollars ($10.00) **and** a notarized copy of your Medicaid, SSI or SSDI Card. **Payment in the form of a Check or Money Order, Payable to RI General Treasurer**

Patient Check List with Caregiver(s)

- ☐ Patient Form
- ☐ Practitioner Form - Send to your practitioner for completion
- ☐ BCI (Background Check(s)) for caregiver(s) - (To obtain BCI contact Attorney General's Office at (401) 274-4400)
  - ☐ Application fees of **either** Seventy-Five Dollars ($75.00) for yourself and each of your caregivers **or** Ten Dollars ($10.00) **and** a notarized copy of Medicaid, SSI or SSDI Card from yourself and each of your caregiver(s) **Payment in the form of a Check or Money Order, Payable to RI General Treasurer**

PATIENT FORM

Office Use Only

Approved By:
Date of Approval:
Registration Number:

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

REGISTRATION FOR MEDICAL MARIJUANA PROGRAM - NEW APPLICATION

Instructions: *Please complete all sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. Please mail the completed form to the address listed above.*
NOTE: You will be contacted to have your identification photograph taken upon application approval.

IMPORTANT: If you are a minor (under 18 years of age), you MUST designate your parent or legal guardian as your caregiver. Your parent or legal guardian must also complete an additional form, entitled "Declaration of Person Responsible for a Minor to Participate" (in the Rhode Medical Marijuana Program). Please attach the completed "Minor form" to this form and then submit both forms to the Department of Health.

A. PATIENT INFORMATION

Patient Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

Would you like to be notified of any clinical studies about marijuana's risk or efficacy? ☐ Yes ☐ No
(These studies may be conducted in or outside of Rhode Island)

B. ATTENDING PRACTITIONER INFORMATION

Practitioner Name (First, M.I., Last)	Telephone Number: ( )
Address:	
City, State, Zip Code:	

C. PRIMARY CAREGIVER #1

Caregiver Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

D. PRIMARY CAREGIVER #2

Caregiver Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

E. PATIENT'S ATTESTATION SIGNATURE AND DATE

I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.

If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete the form; attest to; and sign this statement. I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use "Patient Information Change Request Form"), within ten (10) days of any changes to the information provided.

Patient's Signature:	Date of Signature:
Proxy's Signature (if applicable):	Date of Signature:

This form is to be completed by the Patient or Proxy and is for NEW applications only.

PRACTITIONER FORM

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

ATTENDING PRACTITIONER STATEMENT - NEW APPLICATION

Instructions: *Please complete section "A." and have your practitioner complete all other sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. Please mail the completed form to the above address.*

NOTE: This does NOT constitute a prescription for marijuana

A. PATIENT INFORMATION

Patient Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	

B. PRACTITIONER INFORMATION

Practitioner Name (First, M.I., Last)	License Number:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

C. PRACTITIONER'S STATEMENT

These are the **ONLY** approved qualifying debilitating medical conditions - Check the appropriate box(es):

- ☐ 1. Cancer or the treatment of this condition
- ☐ 2. Glaucoma or the treatment of this condition
- ☐ 3. Positive status for Human Immunodeficiency Virus (HIV) or the treatment of this condition
- ☐ 4. Acquired immune deficiency syndrome (AIDS) or the treatment of this condition
- ☐ 5. Hepatitis C or the treatment of this condition

A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:
(Check all appropriate box(es))

- ☐ 6. Cachexia or wasting syndrome
- ☐ 7. Severe, debilitating, chronic pain
- ☐ 8. Severe nausea
- ☐ 9. Seizures, including but not limited to those characteristic of epilepsy
- ☐ 10. Severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease
- ☐ 11. Agitation related to Alzheimer's Disease

Comments:

PRACTITIONER'S ATTESTATION SIGNATURE AND DATE

I hereby certify that I am a physician duly licensed to practice medicine in one of the following states: Rhode Island, Massachuestts or Connecticut or I am a Physician Assistant or Registered Nurse Practitioner license in Rhode Island. I have a practitioner-patient relationship with the qualifying patient and have completed a full assessment of the patient's medical history. The above-named patient has been diagnosed with a debilitating medical condition as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

Practitioner's Printed Name:

Practitioner's Signature: Date of Signature:

This form is to be completed by the Attending Physician and is for NEW applications only.

MINOR FORM

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

DECLARATION OF PERSON RESPONSIBLE FOR A MINOR TO PARTICIPATE

Instructions: *Please complete all sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. In addition to the patient application form,* ***this form is required if the patient is a minor*** *(under 18 years of age). Please attach this form to the Patient Application Form and mail the completed forms to the address listed above.*

A. PATIENT INFORMATION

Patient Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	
Would you like to be notified of any clinical studies about marijuana's risk or efficacy? ☐ Yes ☐ No (These studies may be conducted in or outside of Rhode Island)	

B. CUSTODIAL PARENT OR LEGAL GUARDIAN INFORMATION

Custodial Parent or Legal Guardian Name	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

DECLARATION

I _____ , do hereby declare:
Custodial Parent or Legal Guardian's Name

1. That I am the Custodial Parent or Legal Guardian with responsibility for health care decisions for:

_____ .
Patient's Name

2. The patient's attending practitioner has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana;
3. I consent to the use of marijuana by the patient for medical purposes;
4. I agree to serve as the patient's designated primary caregiver; AND
5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the patient.

D. SIGNATURES OF CUSTODIAL PARENT OR LEGAL GUARDIAN AND NOTARY PUBLIC

Custodial Parent or Legal Guardian's Signature: Date of Signature:

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation.

Notary Seal

Name of Notary (Print, Type or Stamp):	Signature of Notary:	Notary No./Commission No.:	Commision Expiration:

This form is to be completed by the Custodial Parent or Legal Guardian and is ***required*** *for a Minor Patient.*

Revised 05/12/2010 JCP