

MARIJUANA REGISTRY REGISTERED PATIENT APPLICATION INSTRUCTIONS

1. **BE SURE TO CAREFULLY READ THE PROGRAM INFORMATION WHICH HAS BEEN PROVIDED WITH THIS APPLICATION OR IS AVAILABLE ON OUR WEB SITE AT WWW.DPS.STATE.VT.US.**
2. Complete the Application Form in ink. Have your physician complete the Section that is designated "*PHYSICIAN'S VERIFICATION OF DEBILITATING MEDICAL CONDITION & BONA FIDE PHYSICIAN-PATIENT RELATIONSHIP*". Have your physician return the form to you when it is completed. Do **NOT** have your physician return the form to the Registry.
3. Once the application is completed contact a notary public to notarize your signature.
4. Arrange to have your digital photograph taken. The digital photograph will be used for your Registry Identification Card. You can use your own digital camera, have a digital photograph taken by a studio/store that takes passport photos, or you can arrange to have your photograph taken by the Vermont State Police. (Call 802-241-5115 to make arrangements to have your photo taken by the State Police.) **Make sure that your digital photograph is taken using a .jpeg format.** Have the photo copied to a floppy disk or CD. Label the disk or CD with your name and date of birth and include it with your application.
5. Enclose a check or money order for \$100 made payable to the Department of Public Safety. The Registry cannot accept cash, credit cards, or installment payments. **The Marijuana Policy Project is offering financial assistance to low-income patients who cannot afford the registration fee. For more information, please call 202-462-5747 or send your completed application packet to: Marijuana Policy Project, P.O. Box 77492, Washington, DC 20013.**
6. Mail the completed application with your check and digital photograph to:

Marijuana Registry
Department of Public Safety
103 South Main Street
Waterbury, Vermont 05671
7. **Your application cannot be processed by the Registry until it is complete. A complete application includes the completed forms, a check for \$100, and a digital photograph.**
8. Please call the Registry at 802-241-5115 if you have any questions.

**APPLICATION FORM - REGISTERED PATIENT
MARIJUANA REGISTRY**

Instructions: Please complete all sections labeled “**Required.**” Sections labeled “**Optional**” need to be completed only if they apply to your case. Please type or print your responses on this form **in ink**. A downloadable version of this form may be found at www.dps.state.vt.us. If you have any questions regarding this form please call 802-241-5115.

APPLICANT INFORMATION - REQUIRED

<input type="checkbox"/> Initial Application <input type="checkbox"/> Renewal Application		If renewal application - your ID Number	
Name	Last	First	Middle
Mailing Address	Number	Street/P.O. Box	
	City		State Zip Code
Telephone	Home		Work
Physical Address	(Only if different than mailing address.)		
Date of Birth		VT Driver’s License or Non-Driver ID #	
E-Mail Address (Optional)			

REGISTERED CAREGIVER - OPTIONAL

A person who has agreed to manage the well being of a Registered Patient with respect to the use of marijuana for symptom relief. **My Registered Caregiver will be:**

Name	Last	First	Middle
Mailing Address	Number	Street/P.O. Box	
	City		State Zip Code
Telephone	Home		Work
Physical Address	(Only if different than mailing address.)		
Date of Birth		VT Driver’s License or Non-Driver ID #	
E-Mail Address (Optional)			

SECURE INDOOR FACILITY - OPTIONAL

To be protected by Vermont law a Registered Patient or Registered Caregiver must disclose the location of the building or room that is equipped with locks or other security devices that will be used for the purposes of growing marijuana. **My physical grow site address:**

Street Address	Number	Street
	City	State

If you are using a room in the house, please describe the location of the room:

**PHYSICIAN'S VERIFICATION OF DEBILITATING MEDICAL CONDITION &
BONA FIDE PHYSICIAN-PATIENT RELATIONSHIP**

Registered Patient's	Name, Last	First	Middle
	Date of Birth		Telephone Number

**THE FOLLOWING SECTION SHOULD BE COMPLETED
BY THE REGISTERED PATIENT'S PHYSICIAN**

PHYSICIAN INFORMATION

Name	Last	First	Middle
Office Mailing Address	Number	Street/P.O. Box	
	City		State Zip Code
Office Telephone	Work		Other
VT Physician's License #			

Section 1 - Physician's Verification of a "Debilitating Medical Condition"

Please **initial** the following statements as appropriate.

	I am treating the patient for end of life care for cancer.
	I am treating the patient for end of life care for acquired immune deficiency syndrome.
	I am treating the patient for cancer and the disease, condition or its treatment results in severe, persistent, and intractable symptoms, and reasonable medical efforts have been made over a reasonable amount of time without success in relieving the symptoms.
	I am treating the patient for acquired immune deficiency syndrome and the disease, condition or its treatment results in severe, persistent, and intractable symptoms, and reasonable medical efforts have been made over a reasonable amount of time without success in relieving the symptoms.
	I am treating the patient for positive status for human immunodeficiency virus and the disease, condition or its treatment results in severe, persistent, and intractable symptoms, and reasonable medical efforts have been made over a reasonable amount of time without success in relieving the symptoms.
	I am treating the patient for multiple sclerosis and the disease, condition or its treatment results in severe, persistent, and intractable symptoms, and reasonable medical efforts have been made over a reasonable amount of time without success in relieving the symptoms.
	None of the above statements describe the patient's condition.

**THE FOLLOWING SECTION SHOULD BE COMPLETED
BY THE REGISTERED PATIENT'S PHYSICIAN**

Section 2 - Physician's Verification of a "bona fide physician/patient relationship"

Definition - The phrase "**bona fide physician-patient relationship**" means a treating or consulting relationship of not less than six months duration, in the course of which a physician has completed a full assessment of the registered patient's medical history **and current medical condition**, including a personal physical examination. (18 VSA, Section 4472 (1))

Please initial the appropriate box:

<input type="checkbox"/>	I have a "bona fide physician-patient relationship" with the patient.
<input type="checkbox"/>	I do not have a "bona fide physician-patient relationship" with the patient but the medical condition is of a recent or sudden onset.
<input type="checkbox"/>	I do not have a "bona fide physician-patient relationship" with the patient and the medical condition is not of a recent or sudden onset.

THIS FORM AS COMPLETED IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE USE OF MARIJUANA.

Physician's Signature	Date
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**PLEASE RETURN THIS FORM TO THE PATIENT
WHOSE NAME APPEARS AT THE TOP OF THIS FORM.**

REGISTERED PATIENT’S CERTIFICATION OF DEBILITATING MEDICAL CONDITION

This section is to be completed by a registered patient who does **not** have a “bona fide physician-patient relationship.”

Definitions:

“Bona fide physician-patient relationship” means a treating or consulting relationship of not less than six months duration, in the course of which a physician 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:

1. End of life care for cancer or acquired immune deficiency syndrome; or
2. Cancer, acquired immune deficiency syndrome (AIDS), positive status for human immune deficiency virus, multiple sclerosis (MS), or the treatment of these diseases or medical conditions if the disease, condition or treatment results in severe, persistent, and intractable symptoms; and in the context of the specific disease or condition, reasonable medical efforts have been made over a reasonable amount of time without success in relieving the symptoms.

Please initial the following statements if they apply to you:

	My “debilitating medical condition” as defined above is of recent or sudden onset.
	I have not had a previous physician who is able to verify the nature of the disease and its symptoms.

If you initialed either of the above statements you must attach to this application a copy of relevant portions of your medical records sufficient to establish that you have a debilitating medical condition as defined above. As an alternative to providing your medical records, you may have a physician verify your debilitating condition by completing the “Physician’s Verification of Debilitating Medical Condition & Bona Fide Physician-Patient Relationship Form” on the previous pages.

MARIJUANA REGISTRY PROGRAM ACKNOWLEDGEMENTS

The registering patient must initial each paragraph to acknowledge receipt of the information and their understanding of the information.

	<p>I understand that if my application is approved, my registration is valid for one year. I must renew my registration every year by submitting another application and paying a \$100 fee.</p>
	<p>I understand that if I am notified of a denial I have 7 days to appeal this decision from the time I receive notice of the denial. I understand that if my application is denied I can produce "relevant portions of my medical record" to further verify the physician's check off on this form and will be asked to sign a medical release form if I want those records reviewed by the marijuana registry review board.</p>
	<p>I understand that if my application is approved and I elect to grow marijuana to be used for symptom relief, I may do so only if the marijuana is cultivated in the secure indoor facility identified in this application.</p>
	<p>I understand that if my application is approved and I am in possession of a Marijuana registration card, I may not possess between myself and my registered caregiver more than one mature marijuana plant, two immature plants, and two ounces of usable marijuana.</p>
	<p>I understand that even if my application is approved I may only use marijuana for purposes of symptom relief.</p>
	<p>I understand that even if my application is approved, I may not use marijuana in public, while operating a motorized vehicle, in a workplace, while operating heavy machinery or handling a dangerous instrumentality or in a manner that endangers the health or well-being of another person.</p>
	<p>I understand that if my application is approved, I may not transport marijuana in public unless it is secured in a locked container.</p>
	<p>I understand that a law enforcement officer who finds marijuana or paraphernalia in public from a registered patient or registered caregiver which is not properly secured in a locked container shall not be required to return the marijuana or paraphernalia. A law enforcement officer who finds marijuana being cultivated by a registered patient or registered caregiver, which is not in the single, secure indoor facility identified in this application, shall not be required to return the marijuana or growing paraphernalia to the registered patient or registered caregiver.</p>
	<p>I have instructed my registered caregiver or my next of kin that in the event of my death the Marijuana Registry must be contacted within 72 hours so that a law enforcement agency authorized by the Registry may retrieve and destroy any marijuana or marijuana plants that may have been in our possession.</p>
	<p>I understand that any 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. This penalty shall be in addition to any other penalties that may apply for the possession or use of marijuana.</p>

MARIJUANA REGISTRY PROGRAM

I _____, swear under oath that I have read and understand the above Marijuana Registry Program Acknowledgements and that by my signature I acknowledge that the information I have provided in this application is true and accurate.

TO BE COMPLETED BY A NOTARY

_____ personally appeared before me and having
(Name of Patient)
satisfactorily identified himself/herself, being duly sworn, says that this application is true and accurate. It is subscribed and sworn to before me on

this _____ day of _____, _____

Applicant

Parent or Guardian if applicant is not 18

Notary Public

Date

If the applicant is under 18 please provide the name of a parent or legal guardian.

Name	Last		First		Middle
	Number		Street/P.O. Box		
Mailing Address	City		State	Zip Code	

MAIL COMPLETED FORM TO:

Marijuana Registry
Vermont Criminal Information Center
Vermont Department of Public Safety
103 South Main Street
Waterbury, VT 05671

FOR ADMINISTRATIVE PURPOSES ONLY

Date Application Received	Date Application was Complete
Identification Number	Staff