

Checklist
<input type="checkbox"/> Patient App. & Fee \$75.00 or Fee \$10.00 with Proof of Medicaid, SSI or SSDI
<input type="checkbox"/> Proof of RI Residency
<input type="checkbox"/> Practitioner Form
<input type="checkbox"/> Minor Form (If applicable)
<input type="checkbox"/> Caregiver 1 (if applicable) BCI & Fee \$75.00 or Fee \$10.00 with Proof of Medicaid, SSN or SSDI
<input type="checkbox"/> Caregiver 2 (if applicable) BCI & Fee \$75.00 or Fee \$10.00 with Proof of Medicaid, SSN or SSDI



FOR OFFICE USE ONLY
Approved By:
Date of Approval:
Registration Number:

Rhode Island
Office of Health Professionals Regulation
Medical Marijuana Program

Room 104
 3 Capitol Hill
 Providence, RI 02908-5097

Instructions and Application For
Registration As A

Medical Marijuana Patient

Applicant - Print Name (First/MI/Last)

DO NOT REMOVE THIS PAGE FROM THE APPLICATION
Applications are NOT accepted in Person.
All applications must be mailed to the Department

REGISTRATION REQUIREMENTS

Requirements for Patients

- Must be a Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a RI Driver's License, RI State ID or a copy of a lease agreement **Note: Your name must appear on the document you submit as proof of residency.**
- Complete and Sign a Patient Form
- Submit a Practitioner Form - Practitioner Form must be completed and signed by one of the following practitioner types: Physician (MD, DO) licensed to practice in RI, MA or CT, a Physician Assistant licensed to practice in RI, or a Nurse Practitioner-Prescriptive licensed to practice in Rhode Island.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Seventy-five dollars (\$75.00) **OR** Ten dollars (\$10.00) if you are a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI or SSDI. Proof must accompany the application to be eligible for the reduced fee.
- May designate up to two (2) caregivers.

Requirements for Minor Patients - (Under 18 Years of Age)

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

Requirements for Caregivers

- Caregiver information is ALWAYS provided by the Patient.
- Caregiver's MUST be twenty-one (21) years of age to apply for a caregiver registration.
- Background Check (BCI) for all caregivers. To obtain a BCI contact the Attorney General's Office at (401) 274-4400. Caregivers that live in another state must provide a BCI from the state where they live and also include one from Rhode Island. A new BCI is required **each** time a new application is submitted.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Seventy-five dollars (\$75.00) **OR** Ten dollars (\$10.00) if the caregiver is a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI or SSDI. Proof must accompany the application to be eligible for the reduced fee.
- Each Caregiver may be responsible for up to five (5) patients.

GENERAL INFORMATION

The application process takes 4-6 weeks from the date it is accepted in this office. Applications received that are incomplete will be returned to the patient. **For confidentiality purposes information regarding application status will NOT be given over the phone.** Once you are approved you will receive a letter to come in for your photograph.

Rules and Regulations for the program and forms are available on our website at:

<http://www.health.ri.gov/healthcare/medicalmarijuana>

Changes of Information - (once registered) After you (and your caregiver(s)) receive your registration cards, you can change information by completing a **“Change Form”**, available online at the above website.

Lost Card (s) There is a ten (\$10.00) fee to reprint a new card.

APPLICATION CHECKLIST

Patient Checklist without Caregiver

- Patient Form
- Practitioner Form - Send to your practitioner for completion
- Application Fee (**non-refundable**) 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 Checklist

- 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 a BCI contact the Attorney General's Office at 401-274-4400)
- Application Fee (**non-refundable**) 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 Checklist with Caregiver(s)

- Patient Form
- Practitioner Form - Send to your practitioner for completion
- BCI (Background Check(s)) for caregiver(s) - (To obtain a BCI contact the Attorney General's Office at 401-274-4400)
- Application Fee (**non-refundable**) 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.**



State of Rhode Island Office of Health Professionals Regulation

"PATIENT FORM"

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

Patient Name	<input type="text"/>																								
	First Name																								
	<input type="text"/>																								
	Middle Name																								
	<input type="text"/>																								
Last Name																									
<input type="text"/>																									
Suffix (i.e., Jr., Sr., II, III)																									
<input type="text"/>																									

Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	Patients under 18 years of age MUST designate a custodial parent or legal guardian as one of their primary caregivers. Additionally , a Minor Form must be completed, signed and submitted <u>along with the Patient Form</u>
	Month	Day	Year	

Mailing Address It is your responsibility to notify the department of all address changes.	<input type="text"/>																								
	1st Line Address (Apartment/Suite/Room Number, etc.)																								
	<input type="text"/>																								
	Second Line Address (Number and Street)																								
	<input type="text"/>										<input type="text"/>		<input type="text"/>					-		<input type="text"/>					
	City										State		Zip Code												
	<input type="text"/>			<input type="text"/>			-		<input type="text"/>																
Phone																									
<input type="text"/>																									
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)																									

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)

Practitioner Name and Address Information	<input type="text"/>																								
	First Name																								
	<input type="text"/>																								
	Middle Name																								
	<input type="text"/>																								
	Last Name																								
	<input type="text"/>																								
	Suffix (i.e., Jr., Sr., II, III)																								
	<input type="text"/>																								
	1st Line Address (Apartment/Suite/Room Number, etc.)																								
<input type="text"/>																									
Second Line Address (Number and Street)																									
<input type="text"/>										<input type="text"/>		<input type="text"/>					-		<input type="text"/>						
City										State		Zip Code													
<input type="text"/>			<input type="text"/>			-		<input type="text"/>																	
Phone																									

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 this 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 "Change 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												

**Caregiver (1)
Name and
Address Infor-
mation**

Note: Caregivers must be 21 years of age.

First Name																													
Middle Name																													
Last Name																													
Suffix (i.e., Jr., Sr., II, III)																													
1st Line Address (Apartment/Suite/Room Number, etc.)																													
Second Line Address (Number and Street)																													
																						-							
City															State		Zip Code					-							
			-			Date of Birth:					Month		Day		Year														
Home Phone																	-												
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)																													

**Caregiver (2)
Name and
Address Infor-
mation**

Note: Caregivers must be 21 years of age.

First Name																													
Middle Name																													
Last Name																													
Suffix (i.e., Jr., Sr., II, III)																													
1st Line Address (Apartment/Suite/Room Number, etc.)																													
Second Line Address (Number and Street)																													
																						-							
City															State		Zip Code					-							
			-			Date of Birth:					Month		Day		Year														
Home Phone																	-												
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)																													

**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 this 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 "Change 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



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

PRACTITIONER FORM

Instructions: Please complete patient information 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 attach this form to the Patient Application Form and mail the completed forms to the address listed above.

NOTE: This does NOT constitute a prescription for marijuana

Patient Name, Date of Birth and Phone Number:	<div style="border: 1px solid black; padding: 2px;"> <input style="width:100%; height: 1.2em;" type="text"/> <small>Full Name</small> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <small>Birth Month</small> </div> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <small>Birth Day</small> </div> <div style="text-align: center;"> <input style="width: 50px; height: 1.2em;" type="text"/> <small>Birth Year</small> </div> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <input style="width: 30px; height: 1.2em;" type="text"/> - <input style="width: 30px; height: 1.2em;" type="text"/> <input style="width: 30px; height: 1.2em;" type="text"/> <small>Phone</small> </div> </div>
Practitioner Name, License Number and Address Information	<div style="border: 1px solid black; padding: 2px;"> <input style="width:100%; height: 1.2em;" type="text"/> <small>Full Name</small> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input style="width:100%; height: 1.2em;" type="text"/> <small>License Number</small> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input style="width:100%; height: 1.2em;" type="text"/> <small>1st Line Address (Apartment/Suite/Room Number, etc.)</small> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input style="width:100%; height: 1.2em;" type="text"/> <small>Second Line Address (Number and Street)</small> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="text-align: center;"> <input style="width: 50px; height: 1.2em;" type="text"/> <small>City</small> </div> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <input style="width: 30px; height: 1.2em;" type="text"/> - <input style="width: 30px; height: 1.2em;" type="text"/> <small>State</small> </div> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <input style="width: 30px; height: 1.2em;" type="text"/> - <input style="width: 30px; height: 1.2em;" type="text"/> <small>Zip Code</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <input style="width: 30px; height: 1.2em;" type="text"/> - <input style="width: 30px; height: 1.2em;" type="text"/> <small>Phone</small> </div> <div style="text-align: center;"> <input style="width: 100%; height: 1.2em;" type="text"/> <small>Email Address (Format for email address is Username@domain e.g. applicant@isp.com)</small> </div> </div>

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-(specify) _____
- 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: _____

I hereby certify that I am a physician duly licensed to practice medicine in one of the following states: Rhode Island, Massachusetts or Connecticut or I am a Physician Assistant licensed to practice in Rhode Island or a Nurse Practitioner- Prescriptive licensed to practice 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: _____



Department of Health
Medical Marijuana Program

Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

MINOR FORM

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.

Patient Name and Information

Grid-based form for patient information including Full Name, 1st Line Address, Second Line Address, City, State, Zip Code, Phone, and Email Address.

Date of Birth

Grid-based form for Date of Birth with labels for Month, Day, and Year.

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

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

1. That I am Custodial Parent or Legal Guardian with the 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.

_____,
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.



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