

Checklist
<input type="checkbox"/> Patient App. & Fee \$50.00 or Fee \$25.00 with Proof of Medicaid, SSI, SSDI or Veterans' Disability
<input type="checkbox"/> Proof of RI Residency
<input type="checkbox"/> Practitioner Form
<input type="checkbox"/> Minor Form (If applicable)



FOR OFFICE USE ONLY	
Approved By:	
Date of Approval:	
Registration Number:	
Applicant ID #:	
Receipt #:	
Natural Person Caregiver	<input type="checkbox"/>
Authorized Purchaser	<input type="checkbox"/>

Rhode Island
Center for Professional Licensing
 Room 105A - 3 Capitol Hill
 Providence, RI 02908-5097

Instructions and Application For
Initial Registration As A

Medical Marijuana Patient

Have you EVER held a registration as a medical marijuana patient in Rhode Island? Yes No

If yes, DO NOT Complete this initial application. Please email doh.mmp@health.ri.gov to obtain the correct renewal application.

Applicant - Print Name (First/MI/Last)

DO NOT REMOVE PAGES FROM THE APPLICATION
PLEASE SEND ALL PAGES OF THIS APPLICATION WITH PAYMENT
In order to ensure timely delivery and avoid unexpected delays, please send your ORIGINAL completed application by regular US mail. Photocopies not accepted.

Phone: (401) 222-3752

TTY/TDD: (800) 745-5555

Fax: (401) 222-1745

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 gas or electric bill. Note: Your name and current address must appear on the document you submit as proof of residency.
- Complete and Sign a Patient Form
- Submit a Practitioner Form - Practitioner Written Certification Form must be completed and signed by one of the following practitioner types: Physician (MD, DO) licensed to practice in RI, MA or CT.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Fifty dollars (\$50.00) **OR** Twenty-five dollars (\$25.00) if you are a recipient of Medicaid, Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Federal Railroad Disability benefit. (**NOT Social Security or Medicare**) or Veterans' Disability Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI, SSDI or Veterans' Disability. Proof must accompany the application to be eligible for the reduced fee. Verification of your SSI or SSDI eligibility can be obtained at <http://www.ssa.gov>. Note: If the patient's physician provides a written statement indicating the patient is Hospice Eligible there is no fee for the patient registration.
- You can designate one (1) caregiver and/or one (1) authorized purchaser. The law requires caregivers and authorized purchasers to obtain a background check from the National Criminal Information Center (NCIC). In addition, caregivers or authorized purchasers can be disqualified for a variety of felony charges, not just felony drug convictions. (**See pages 6 and 7 for application fees and instructions for caregivers and authorized purchasers.**)

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 their primary caregiver or authorized purchaser. Additionally, a Minor Form must be completed, signed and submitted along with the Patient Form as described above.

GENERAL INFORMATION

Please send in all pages of this application together with payment and other required documentation. Do not separate or mail pages separately. Application must be ORIGINAL. Photocopies will not be accepted.

Please keep a copy of your application. The Department does not make copies of applications for the public.

The application process takes 2-4 weeks from the date it is accepted in this office. Applications received that are incomplete will be returned to the patient and the processing time will start over. 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.

You can use any of the three compassion centers in Rhode Island without registering.

License Number - MCC00001 THOMAS C SLATER COMPASSION CENTER INC 1 CORLISS STREET PROVIDENCE, RI 02904 (401) 274-1000	License Number - MCC00002 GREENLEAF COMPASSION CENTER 1637 WEST MAIN ROAD PORTSMOUTH, RI 02871 (401) 293-5987	License Number MCC00003 SUMMIT MEDICAL COMPASSION CENTER INC UNIT E2 380 JEFFERSON BOULEVARD WARWICK, RI 02886 (401) 889-3990
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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 and/or authorized purchaser) receive your registration cards, you can change information by completing a **"Change Form"**, available online at the above website. If you have any questions regarding patient, caregiver or authorized purchaser applications please call 401-222-3752 or email doh.mmp@health.ri.gov.

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



State of Rhode Island - Center for Professional Licensing

"PATIENT FORM"

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

Patient Name	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 50%; height: 20px;"></td> <td style="border: 1px solid black; width: 50%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">First Name</td> <td style="font-size: 8px;">Middle Name</td> </tr> <tr> <td style="border: 1px solid black; width: 50%; height: 20px;"></td> <td style="border: 1px solid black; width: 50%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">Last Name</td> <td style="font-size: 8px;">Suffix (i.e., Jr., Sr., II, III)</td> </tr> </table>			First Name	Middle Name			Last Name	Suffix (i.e., Jr., Sr., II, III)																					
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Home Address and Contact Info It is your responsibility to notify the department of all address changes.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">1st Line Address (Apartment/Suite/Room Number, etc.)</td> </tr> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">Second Line Address (Number and Street)</td> </tr> <tr> <td> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 40%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">City</td> <td style="font-size: 8px;">State</td> <td style="font-size: 8px;">Zip Code</td> <td style="font-size: 8px;">-</td> <td style="font-size: 8px;"></td> <td style="font-size: 8px;"></td> </tr> </table> </td> </tr> <tr> <td style="border: 1px solid black; width: 20%; height: 20px;"></td> <td style="border: 1px solid black; width: 20%; height: 20px;"></td> <td style="border: 1px solid black; width: 20%; height: 20px;"></td> <td style="border: 1px solid black; width: 20%; height: 20px;"></td> <td style="border: 1px solid black; width: 20%; height: 20px;"></td> <td style="border: 1px solid black; width: 20%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">Phone</td> <td style="font-size: 8px;">-</td> <td style="font-size: 8px;"></td> <td style="font-size: 8px;"></td> <td style="font-size: 8px;"></td> <td style="font-size: 8px;"></td> </tr> </table> <p style="font-size: 8px;">Email Address (Format for email address is Username@domain e.g. applicant@isp.com) If you answer Yes to the question below this Email will be shared with whoever is conducting a study</p>		1st Line Address (Apartment/Suite/Room Number, etc.)		Second Line Address (Number and Street)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 40%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> <td style="border: 1px solid black; width: 10%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">City</td> <td style="font-size: 8px;">State</td> <td style="font-size: 8px;">Zip Code</td> <td style="font-size: 8px;">-</td> <td style="font-size: 8px;"></td> <td style="font-size: 8px;"></td> </tr> </table>							City	State	Zip Code	-									Phone	-				
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Do you intend to grow marijuana in the coming year? Yes No

If you grow marijuana you must purchase tags from the Department of Business Regulations (DBR).

Would you like to be notified of any clinical studies about marijuana's risk or efficacy? Yes No

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Patient's Attestation Signature and Date	<p>I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.</p> <p>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, Center for Professional Licensing, Medical Marijuana Program, in writing (use "Change Form") within ten (10) days of any changes to the information provided.</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>								
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**Department of Health
Center for Professional Licensing**
Room 105A - 3 Capitol Hill
Providence, RI 02908-5097

PRACTITIONER WRITTEN CERTIFICATION 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: 40px; height: 1.2em;" type="text"/> <small>Birth Year</small> </div> <div style="text-align: center;"> <input style="width: 30px; height: 1.2em;" type="text"/> <small>Phone</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"/> </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: 30px; height: 1.2em;" type="text"/> <small>City</small> </div> <div style="text-align: center;"> <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"/> <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"/> <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):

- Cancer or the treatment of this condition; including chemotherapy, radiation, etc.
- Glaucoma or the treatment of this condition
- Positive status for Human Immunodeficiency Virus (HIV) or the treatment of this condition
- Acquired immune deficiency syndrome (AIDS) or the treatment of this condition
- 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))

- Cachexia or wasting syndrome
- Severe, debilitating, chronic pain-(specify) _____
- Severe nausea
- Seizures, including but not limited to those characteristic of epilepsy
- Severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease
- Agitation related to Alzheimer's Disease
- Post Traumatic Stress Disorder (PTSD) - Patient must be 18 years or older

Comments: Practitioner means a person who is licensed with authority to prescribe drugs pursuant to chapter 37 of title 5 or a physician licensed with authority to prescribe drugs in Massachusetts or Connecticut.

I hereby certify that I am a practitioner as defined above. 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.

This patient is eligible for hospice care.

Practitioner's Printed Name: _____

Practitioner's Signature: _____ Date of Signature: _____



Department of Health
Center for Professional Licensing
 Room 105A - 3 Capitol Hill
 Providence, RI 02908-5097
 401-222-3752 - www.health.ri.gov/hsr/mmp

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	<table style="width: 100%;"> <tr><td colspan="3">Full Name</td></tr> <tr><td colspan="3"><input style="width: 100%; height: 20px;" type="text"/></td></tr> <tr><td colspan="3">1st Line Address (Apartment/Suite/Room Number, etc.)</td></tr> <tr><td colspan="3"><input style="width: 100%; height: 20px;" type="text"/></td></tr> <tr><td colspan="3">Second Line Address (Number and Street)</td></tr> <tr><td colspan="3"><input style="width: 100%; height: 20px;" type="text"/></td></tr> <tr> <td style="width: 60%;">City</td> <td style="width: 10%;">State</td> <td style="width: 30%;">Zip Code</td> </tr> <tr> <td><input style="width: 100%; height: 20px;" type="text"/></td> <td><input style="width: 20px; height: 20px;" type="text"/></td> <td><input style="width: 100%; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>Phone</td> <td colspan="2"></td> </tr> <tr> <td><input style="width: 100%; height: 20px;" type="text"/></td> <td colspan="2"></td> </tr> <tr> <td colspan="3">Email Address (Format for email address is Username@domain e.g. applicant@isp.com)</td> </tr> <tr> <td colspan="3"><input style="width: 100%; height: 20px;" type="text"/></td> </tr> </table>	Full Name			<input style="width: 100%; height: 20px;" type="text"/>			1st Line Address (Apartment/Suite/Room Number, etc.)			<input style="width: 100%; height: 20px;" type="text"/>			Second Line Address (Number and Street)			<input style="width: 100%; height: 20px;" type="text"/>			City	State	Zip Code	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	Phone			<input style="width: 100%; height: 20px;" type="text"/>			Email Address (Format for email address is Username@domain e.g. applicant@isp.com)			<input style="width: 100%; height: 20px;" type="text"/>		
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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.)

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 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/or authorized purchaser; by completing the attached caregiver and/or authorized purchaser application and paying the appropriate fee. (see page 6/7)
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:
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This form is to be completed by the Custodial Parent or Legal Guardian and is required for a Minor Patient.



Department of Health
Center for Professional Licensing
 Room 105A - 3 Capitol Hill
 Providence, RI 02908-5097
 401-222-3752 - www.health.ri.gov/hsr/mmp

Registration Number:
Applicant ID #:
Receipt #:

NATURAL PERSON CAREGIVER - INITIAL APPLICATION

Caregiver information is ALWAYS provided by the Patient.

Caregiver's 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 gas or electric bill. **Note: Your name and current address must appear on the document you submit as proof of residency.**

Caregiver's MUST be twenty-one (21) years of age to apply for a caregiver registration.

National Criminal Information Center (NCIC). To obtain the background check you must contact your local police department, the department of the attorney general, or by appointment with the state police (401-444-1110). Attached is a form for your convenience. Caregiver must retain a copy of the records check results in case you wish to become a caregiver for additional patient(s). Your copy will be considered valid for up to 2 years. **Note:** Caregivers can be disqualified for a variety of felony charges and not just felony drug convictions.

Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**)

One hundred dollars (\$100.00) **OR** Twenty-five dollars (\$25.00) if the caregiver is a recipient of Medicaid, Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Veterans' Disability or Federal Railroad disability benefit. Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI, SSDI (**NOT Social Security or Medicare**) or Veterans' Disability. Proof must accompany the application to be eligible for the reduced fee. Note: If the patient's physician provides a written statement indicating the patient is Hospice Eligible there is no fee for the caregiver registration.

Each Caregiver may be responsible for up to five (5) patients.

Caregiver Name	<table border="1"> <tr> <td colspan="25">First Name</td> </tr> <tr> <td colspan="25">Middle Name</td> </tr> <tr> <td colspan="25">Last Name</td> </tr> <tr> <td colspan="10">Suffix (i.e., Jr., Sr., II, III)</td> </tr> </table>	First Name																									Middle Name																									Last Name																									Suffix (i.e., Jr., Sr., II, III)																															
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Department of Health

Center for Professional Licensing, Room 105A
 3 Capitol Hill, Providence, RI 02908-5097
 401-222-3752
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Registration Number:
Applicant ID #:
Receipt #:

AUTHORIZED PURCHASER - INITIAL APPLICATION

Authorized Purchaser information is ALWAYS provided by the Patient.

Authorized Purchaser MUST be twenty-one (21) years of age to apply for a registration.

National Criminal Information Center (NCIC). To obtain the background check you must contact your local police department, the department of the attorney general, or by appointment with the state police (401-444-1110). Attached is a form for your convenience. Authorized Purchaser must retain a copy of the records check results. Your copy will be considered valid for up to 2 years. **Note:** Authorized Purchasers can be disqualified for a variety of felony charges and not just felony drug convictions.

Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**)
 Fifty dollars (\$50.00)

Each Authorized Purchaser can only be responsible for one (1) patient at a time.

Authorized Purchaser Name	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">First Name</td> </tr> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">Middle Name</td> </tr> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">Last Name</td> </tr> <tr> <td style="border: 1px solid black; width: 100%; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">Suffix (i.e., Jr., Sr., II, III)</td> </tr> </table>		First Name		Middle Name		Last Name		Suffix (i.e., Jr., Sr., II, III)																						
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NATIONAL CRIMINAL INFORMATION CENTER - (NCIC)

In accordance with Rhode Island General Laws, all applicants for Medical Marijuana Caregiver/Authorized Purchaser must obtain a background check from the National Criminal Information Center (NCIC). As part of this check your fingerprints will be taken. Caregivers and Authorized Purchasers can be disqualified for a variety of felony charges (not just felony drug convictions).

TO: MEDICAL MARIJUANA CAREGIVER/AUTHORIZED PURCHASER

Please obtain a background check (NCIC) from your local police department, the Rhode Island Department of the Attorney General or by appointment with the Rhode Island State Police (401-444-1110). As part of the NCIC your fingerprints will be taken. Once the check has been processed the results will be sent directly to the Department of Health and a copy will be sent to you.

Please bring this to the law enforcement agency and inform them that you are applying to become a Medical Marijuana Caregiver/Authorized Purchaser so that the results of the check are routed to the correct office.

Medical Marijuana Caregiver/Authorized Purchaser Applicant Name: _____

Medical Marijuana Caregiver/Authorized Purchaser Applicant Date of Birth: _____ / _____ / _____
Month Day Year

Medical Marijuana Caregiver/Authorized Purchaser Applicant Address:

TO: LAW ENFORCEMENT AGENCY

Please provide a National Criminal Information Center Check (NCIC) which shall include fingerprints for the above-named Medical Marijuana Caregiver/Authorized Purchaser applicant. Please send the "Qualify/Does Not Qualify" letter to:

Center for Professional Licensing
Room 105A
Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908
Email: doh.mmp@health.ri.gov