Checklist
☐ Patient App. & Fee $75.00 or Fee $10.00 with Proof of Medicaid, SSI or SSDI
☐ Proof of RI Residency
☐ Practitioner Form
☐ Minor Form (If applicable)
☐ Caregiver 1 (if applicable) BCI & Fee $75.00 or Fee $10.00 with Proof of Medicaid, SSN or SSDI
☐ 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 Marijauna 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)

Applications are NOT accepted in Person.
All applications must be mailed to the Department

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 01/04/2012 jcp

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 confidentialtiy 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

First Name

Middle Name

Last Name

Suffix (i.e., Jr., Sr., II, III)

Date of Birth

Month Day Year

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 along with the Patient Form

Mailing Address

It is your responsibility to notify the department of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Phone –

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

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 –

Phone –

Caregiver (1) Name and Address Information

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

Home Phone

Date of Birth: Month | Day | Year

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Caregiver (2) Name and Address Information

Note: Caregivers must be 21 years of age.

First Name

Middle Name

Last Name

Suffix (i.e., Jr., Sr., II, III)

Date of Birth: Month | Day | Year

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

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:

Full Name

Birth Month | Birth Day | Birth Year | Phone

Practitioner Name, License Number and Address Information

Full Name

License Number

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

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, Massachuestts 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: _____

This form is to be completed by the Attending Practitioner.

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 <u>required</u> if the patient is a minor*** *(under 18 years of age). <u>Please attach this form to the Patient Application Form and mail the completed forms to the address listed above.</u>*

Patient Name and Information

Full Name

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Date of Birth

Month | Day | Year

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:

_____
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.

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.*