__FOR INTERNAL USE ONLY**__**
Approved by: ___________________________
Date of Approval: ________________________
Registration Number: _____________________

Government of the District of Columbia

Department of Health

Health Regulation & Licensing Administration
Medical Marijuana Program

Instructions and Application for Registration as a
Medical Marijuana ***Patient***

____
Applicant- Print Name (First/MI/Last)

Return Completed Application by Mail with Payment to:

DC Medical Marijuana Program
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

DO NOT REMOVE THIS PAGE FROM THE APPLICATION

APPLICATION INSTRUCTIONS

To apply for a patient registration identification card, applicants shall submit a completed application to the Department on the required form, which shall include;

1. Patient Application Form, *including*:
   - ➢ Two (2) recent passport-type photographs as specified below
   - ➢ Clear photocopy of a U.S., state, or District government-issued photo ID as proof of identity
2. Caregiver Application Form (if applicable)
3. Physician Recommendation Form
   - ➢ This must be dated no longer than ninety (90) days prior to the application date
4. Proof of District Residency *(for residency requirements, see page 9)*
5. Payment of the Application Fee

Mail your completed application to: DC Medical Marijuana Program
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

Minors

If patient is under 18, please use the patient application for minors.

Social Security Number

If an applicant does not have a social security number:

(1) Submit with the application a sworn affidavit, under penalty of perjury, stating that the applicant does not have a social security number

(2) Provide the Department of Health with social security information once a social security number has been obtained

Photo Identification

Attach to the application two (2) recent passport-type photographs of the applicant's face measuring two inches by two inches (2" x 2"), which clearly exposes the area from the top of the forehead to the bottom of the chin.

LIMITATION OF LIABILITY – The District of Columbia shall not be liable to the registrant, its employees, agents, business invitees, licensees, customers, clients, family members or guests for any damage, injury, accident, loss, compensation or claim, based on, arising out of or resulting from registrant's participation in the District of Columbia's medical marijuana program, including but not limited to the following: arrest and seizure of persons and/or property, prosecution pursuant to federal laws by federal prosecutors, interruption in registrant's ability to operate its medical marijuana cultivation center and/or dispensary; any fire, robbery, theft, mysterious disappearance or any other casualty; the actions of any other registrants or persons within the cultivation center and /or dispensary. This Limitation of Liability provision shall survive expiration or the earlier termination of this registration if such registration is granted; and

FEDERAL PROSECUTION – The United States Congress has determined that marijuana is a controlled substance and has placed marijuana in Schedule I of the Controlled Substance Act. Growing, distributing, and possessing marijuana in any capacity, other than as a part of a federally authorized research program, is a violation of federal laws. The District of Columbia's law authorizing the District's medical marijuana program will not excuse any registrant from any violation of the federal laws governing marijuana or authorize any registrant to violate federal laws.

REGISTRATION FEES

All registration and permit fees must be paid by certified check, money order, or cashier's check payable to the **DC Treasurer**. Fees must be paid at the time an application is filed.

I. The registration, renewal and replacement fees are as follows:

- Initial registration fee $100.00
- Renewal fee $100.00
- Replacement card fee $90.00

II. Reduced Fees

The initial registration fees for a qualifying patient or caregiver whose income is *equal to or less than two hundred percent (200%) of the federal poverty level* will be twenty-five percent (25%) of the published standard qualifying patient or caregiver registration fee as follows:

- Initial registration fee $25.00
- Renewal fee $25.00
- Replacement card fee $20.00

In verifying income for reduced fees, applicants must supply proof of the following:

- Proof of being a current Medicaid or DC Alliance recipient; or
- Documentation verifying that the applicant's total gross income, including child support payments, alimony and rent payments received and any other income received on a regular basis, is equal to or less that 200% of the federal poverty level, as defined by the US Department of Health and Human Services.

  In verifying income for the purposes of this qualification, an individual may submit the following:
  - Earnings statements received within the previous thirty (30) days
  - District of Columbia or Federal tax filing returns for the most recent tax year;
  - For newly employed applicants, a verifiable copy of an offer of employment that states the amount of salary to be paid;
  - A copy of a Social Security or worker's compensation benefit statement;
  - Proof of child support or alimony received;
  - Any other unearned income or assets, including but not limited to, stocks, bonds, annuities, private pension and retirement accounts; or
  - Any other item(s) of proof deemed by the Director of the Department of Health or the Director's agent reasonably calculated to demonstrate a person's current income.

Applicants must submit the required verifying information for each renewal or request for a replacement card in order to receive the reduced fee.

District of Columbia
Health Regulation & Licensing Administration
Patient Application Form

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

Patient Name	First Name ______ Middle Initial ______ Last Name ______ Suffix (i.e., Jr., Sr., II, III) ______
Social Security Number	___ ___ ___ - ___ ___ - ___ ___ ___ ___ *If applicant does not have a Social Security Number, see Application Instructions (page 2).
Date of Birth	______ Month ______ Day ______ Year *If patient is under 18, please use the patient application for minors
Mailing Address It is your responsibility to notify the department of all address changes.	Street (PO Box NOT acceptable) ______ Apt/Suite ______ City ______ State ______ Zip Code ______ (______)______ Phone Number ______ Email Address
Physician Name and Office Address Information	First Name ______ Middle Initial ______ Last Name ______ Suffix (i.e., Jr., Sr., II, III) ______ Street ______ Apt/Suite ______ City ______ State ______ Zip Code ______ (______)______ Phone Number ______ Email Address

Dispensary	____ Name of Dispensary ____ Street Zip Code
Caregiver Name and Address Information Note: Caregivers must be 18 years of age	____ First Name Middle Initial ____ Last Name Suffix (i.e., Jr., Sr., II, III) ____ Street Apt/Suite _____________________ _____ ___________ City State Zip Code (______)__________________ ________________________________ Phone Number Email Address ___________________ Date of Birth

PATIENT ATTESTATION

(*Initial each line*)

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

_____ I assume any and all risk or liability that may result under District of Columbia and federal laws from the possession, use, administration, or dispensing of medical marijuana. I further acknowledge that I understand that the medical marijuana laws and enforcement thereof of the District of Columbia and the Federal government are subject to change at any time.

_____ I understand that the registration identification card is not transferable. I understand that my registration card is the property of the District of Columbia and shall be surrendered upon demand of the Director of the Department of Health.

_____ I specifically acknowledge receipt and advisement of the notices below. The undersigned agrees to and accepts the limitation of liability against the District, and the requirement to indemnify, hold harmless, and defend the District.

(a) **Limitation of Liability –** The District of Columbia shall not be liable to the registrant, its employees, agents, business invitees, licensees, customers, clients, family members or guests for any damage, injury, accident, loss, compensation or claim, based on, arising out of or resulting from registrant's participation in the District of Columbia's medical marijuana program, including but not limited to the following: arrest and seizure of persons and/or property, prosecution pursuant to federal laws by federal prosecutors, interruption in registrant's ability to operate its medical marijuana cultivation center and/or dispensary; any fire, robbery, theft, mysterious disappearance or any other casualty; the actions of any other registrants or persons within the cultivation center and /or dispensary. This Limitation of Liability provision shall survive expiration or the earlier termination of this registration if such registration is granted; and

(b) **Federal Prosecution** – The United States Congress has determined that marijuana is a controlled substance and has placed marijuana in Schedule I of the Controlled Substance Act. Growing, distributing, and possessing marijuana in any capacity, other than as a part of a federally authorized research program, is a violation of federal laws. The District of Columbia's law authorizing the District's medical marijuana program will not excuse any registrant from any violation of the federal laws governing marijuana or authorize any registrant to violate federal laws.

_____ I understand that I must notify the Department of Health in writing within 14 calendar days of any changes to my name, address, caregiver, recommending physician, or designated dispensary. I shall submit the change of information form provided by the Department; surrender my current registration identification card; notify my caregiver; pay the required fee; and will be issued a new card that reflects the changes.

_____ I understand that within 14 calendar days of the recommending physician declaring that I no longer suffer from a qualifying medical condition or treatment, I shall surrender my registration card to the Department of Health; notify my caregiver of the change; and return any unused medical marijuana to the District of Columbia Metropolitan Police Department.

_____ I understand that in the event that I experience theft, loss, or destruction of my registration card I shall provide verbal notification to the Department of Health within 24 hours after discovery of the theft, loss or destruction; submit written notification within 72 hours after the discovery; pay the required fee; and will be issued a new registration identification card.

_____ I understand that I shall only possess and administer medical marijuana, or use paraphernalia, for the treatment of a qualifying medical condition or the side effects of the qualifying medical treatment after obtaining a signed, written recommendation from a physician in accordance with the regulations and registering with the Department of Health.

_____ I understand that I shall only possess or administer medical marijuana, or possess or use paraphernalia, obtained from the registered dispensary designated on my registration identification card.

_____ I understand that I shall only transport medical marijuana in a container or sealed package bearing the label received from the dispensary.

_____ I understand that I shall not administer or use medical marijuana at a dispensary or cultivation center.

_____ I understand that I shall not administer or use medical marijuana anywhere other than my residence, if permitted or at a medical treatment facility when receiving medical care for a qualifying medical condition, if permitted by the medical facility.

_____ I understand that I shall not use medical marijuana at a time or in a location within my residence when such use would result, or is likely to result, in exposure to the medical marijuana smoke that may adversely affect the health, safety, or welfare of a minor.

_____ I understand that the maximum amount of medical marijuana that I may possess at any time is two ounces of dried medical marijuana or the equivalent of two ounces of dried medical marijuana when sold in any other form.

_____ I understand that the Medical Marijuana Program shall not be construed as permitting me to undertake any task under the influence of medical marijuana when doing so would constitute negligence or professional malpractice; or operate, navigate, or be in actual physical control of any motor vehicle, aircraft or motorboat while under the influence of medical marijuana.

_____ I understand that I shall not engage in abusive, intimidating, threatening, or disruptive conduct while on the premises of a dispensary.

_____ I understand that I shall not transfer, share, give, or deliver any unused medical marijuana in my possession to another qualifying patient or caregiver for medical use or destruction whether or not the person is registered with the District's Medical Marijuana Program.

_____ I understand that I shall not grow or cultivate medical marijuana.

_____ I understand that I shall not purchase medical marijuana through street vendors.

_____ I understand that I shall not obtain medical marijuana from other registered qualifying patients or caregivers.

_____ I understand that the Department of Health may deny my application if the application is incomplete and I fail to provide the missing information or documentation within 60 days of notification by the Department or if the Department of Health determines after further inquiry or investigation that the information provided was false, misleading, forged, or altered.

_____ I certify that the application is complete and accurate.

Any person who knowingly makes a false statement on an application, or in any accompanying statement under oath that the Department may require, whether made with or without the knowledge or consent of the applicant, shall, in the discretion of the Director, constitute sufficient cause for denial of the application or revocation of the registration. The making of false statements shall also constitute the basis for a criminal offense under D.C. Official Code §22-2514.

_____ I attest this willingly and without reservation, and I am fully aware of its meaning and effect.

____
Qualifying Patient's Signature

____
Qualifying Patient's Printed Name

____
Date

District of Columbia
Health Regulation & Licensing Administration

Proof of Residency/Identity Form

In order to qualify for the Medical Marijuana Program, you must be a resident of the District of Columbia. For purposes of this subtitle, a patient shall be a resident of the District of Columbia if the individual: (a) Is physically present in the District of Columbia; (b) Has taken verifiable actions to make the District his or her home indefinitely with no present intent to reside elsewhere; and (c) Is not merely present in the District for the sole purpose of obtaining medical marijuana.

To prove District of Columbia residency, applicants must submit at least **TWO (2)** of the following items in the name of the applicant. Check two forms of residency from the list below and attach the according documents to the application.

___ Proof of payment of District of Columbia personal income tax, in the name of the applicant, for the tax period closest in time to the application date

___ A property deed for a District of Columbia residence showing the applicant as an owner or co-owner

___ A valid unexpired lease or rental agreement in the name of the applicant on a District of Columbia residential property

___ A pay stub issued less than forty-five (45) days prior to the application date which shows evidence of the applicant's withholding of District income tax

___ A voter registration card with an address in the District of Columbia

___ Current official documentation of financial assistance received from the District Government including, but not limited to Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income (SSI), housing assistance, or other governmental programs

___ A current motor vehicle registration in the name of the applicant evidencing District residency

___ A valid unexpired District motor vehicle operator's permit or other official non-driver identification in the name of the applicant

___ A utility bill (excluding telephone bill) from a period within the two (2) months immediately preceding the application date in the name of the applicant on a District of Columbia residential address

___ Any other reasonable form of verification deemed by the Director or the Director's agent to demonstrate proof of current residency

PROOF OF IDENTITY

In addition, an applicant shall attach one (1) clear photocopy of U.S., state, or District government-issued photo ID, such as a driver's license, as proof of identity.