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
Date of Birth	_____ _____ _____ *If patient is under 18, please use the patient application Month Day Year 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 (select one)	O Capital City…….1334 N. Capitol Street NW, Washington, DC 20002 O Metropolitan Wellness….409 8th Street SE, Washington, DC 20003 O Takoma Wellness…….6925 Blair Road NW, Washington, DC 20012
Optional **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 _____ _____ Date of Birth Email Address
Patient's Attestation Signature and Date	**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. **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 hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge. I acknowledge receipt and advisement of the notices above, and I agree to and accept the limitation of liability against the District. I assume any and all risk or liability that may result under the District of Columbia or federal laws arising from the possession, use, or cultivation, administration, or dispensing of medical marijuana. 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 sign this attestation willingly and without reservation and am fully aware of its meaning and effect. _____ _____ Patient's Signature Date

Remember to include:

- ✓ Two recent passport photos (2" x 2")
- ✓ Photocopy of U.S., state, or District government-issued photo ID
- ✓ Pink copy of Physician Recommendation Form
- ✓ Application fee (paid by Certified check, money order, or cashier's check made payable to DC Treasurer)
- ✓ 2 forms of proof of DC residency (acceptable forms of proof residency listed in application instructions)

For more information, please see Application Instructions under the **Patients** section of the Medical Marijuana Program webpage: http://doh.dc.gov/mmp

NOTE:
Please allow at least 3 business days before contacting the Department of Health to check on the status of your application