DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

Government of the District of Columbia

Department of Health

Health Regulation and Licensing Administration

Medical Marijuana Program

WE ARE WASHINGTON DC

FEE PAYMENT(check one)

☐ *$100.00*

☐ *$25.00 (submit proof of low income)*

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

☐ **Initial** ☐ **Renewal**	**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, use minor patient application Month Day Year
Mailing Address It is your responsibility to notify the Department of all address changes	______________________________ Street (P .O. Box NOT acceptable) Apt/Suite ______________ _______ _______ City State Zip Code (___)____________ __________________ Phone Number Email Address
Healthcare Practitioner Name and Office Address Information **Select one:** ☐ Physician (MD, DO) ☐ APRN/ NP ☐ Physician Assistant (PA) ☐ Dentist ☐ Naturopathic Physician	______________________________ First Name Middle Initial ______________________________ Last Name Suffix(i.e., Jr., Sr., II,III) ______________________________ Street (P .O. Box NOT acceptable) Apt/Suite ______________ _______ _______ City State Zip Code (___)____________ __________________ Phone Number Email Address

Dispensary (Select one)	○ Capital City……………………..1334 N. Capitol Street NW, Washington, DC 20002 ○ Metropolitan Wellness…….409 8th Street SE, Washington , DC 20003 ○ Takoma Wellness…………….6925 Blair Road NW, Washington , DC 20012 ○ Herbal Alternative…….1710 Rhode Island Avenue NW, Washington, DC 20036 ○ National Holistic Healing Center……1718 Connecticut Ave. NW, Washington, DC 20009
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

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General’s hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General’s website at oig.dc.gov.

Remember to include:

✓ Two recent passport photos (2” x 2”)

✓ Photocopy of U.S., state, or District government-issued photo ID

✓ 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)

✓ Electronic Healthcare Practitioner Recommendation

899 North Capitol Street, N.E., 2nd Floor, Washington, DC 20002 Email: doh.mmp@dc.gov
Website: http://doh.dc.gov/mmp

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