

**Health Regulation and Licensing Administration  
Division of Medical Marijuana and Integrative Therapy  
Minor Application Form**

<b>Minor Name</b>	First Name	Middle Initial	
	Last Name	Suffix (i.e., Jr., Sr., II, III)	
	Social Security Number		
<b>Social Security Number</b>	*If applicant does not have a Social Security Number, see Application Instructions (page 2)		
<b>Date of Birth</b>	Month	Day	Year
	*Note: Parent or Guardian must be at least 18 years of age		
<b>Residential Mailing Address</b>  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
<b>Parent or Guardian Name Address Information</b>	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
	Date of Birth		

<p><b>Application Checklist</b></p>	<ul style="list-style-type: none"> <li>○ Two recent (2) Passport photos (2"x 2")</li> <li>○ Photocopy of U.S., State, or District government-issued Real ID</li> <li>○ Application fee (paid by certified check, money order or cashier's check payable to DC Treasurer)</li> <li>○ \$25.00 (Submit proof of low income)</li> <li>○ \$100.00</li> <li>○ Two (2) forms of proof of residency</li> <li>○ Electronic HealthCare Practitioner Recommendation</li> </ul>
<p><b>Healthcare Practitioner Name, Office Address Information and Recommendation Number</b></p> <p><b>Select one:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Physician (MD, DO)</b></li> <li><input type="checkbox"/> <b>Nurse Practitioner/ APRN</b></li> <li><input type="checkbox"/> <b>Physician Assistant (PA)</b></li> <li><input type="checkbox"/> <b>Naturopathic</b></li> <li><input type="checkbox"/> <b>Physician</b></li> </ul>	<hr/> <p>First Name _____ Middle Initial _____</p> <hr/> <p>Last Name _____ Suffix (i.e., Jr. Sr., II, III) _____</p> <hr/> <p>Street (P.O. Box NOT acceptable) _____ Apt/Suite _____</p> <hr/> <p>City _____ State _____ Zip Code _____</p> <hr/> <p>( _____ ) Phone Number _____ Email _____</p> <hr/> <p>Recommendation Number _____</p>

<p><b>Patient's and Parent's Attestation Signature and Date</b></p>	<p><b>Limitation of Liability</b> – 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.</p> <p><b>Federal Prosecution</b> - 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.</p> <p>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.</p> <p style="text-align: center;"> <span style="display: inline-block; width: 150px; border-bottom: 1px solid black; margin-bottom: 5px;"></span> <span style="display: inline-block; width: 150px; border-bottom: 1px solid black; margin-bottom: 5px;"></span> </p> <p style="text-align: center;"> <span style="display: inline-block; width: 150px; border-bottom: 1px solid black; margin-bottom: 5px;"></span> <span style="display: inline-block; width: 150px; border-bottom: 1px solid black; margin-bottom: 5px;"></span> </p> <p style="text-align: center;"><b>All fees are non-refundable</b></p>
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