****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 **Caregiver***

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

Return Completed Application by Mail with Payment to:

DOH – Medical Marijuana
P.O. Box 37804
Washington, D.C. 20013

DO NOT REMOVE THIS PAGE FROM THE APPLICATION

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.

APPLICATION INSTRUCTIONS

To Qualify to Be a Caregiver, Applicants:

- Must be designated by a patient to serve as the person authorized, on the patient's behalf, to possess, obtain from a dispensary, dispense, and assist in the administration of medical marijuana
- Be registered with the Department of Health as the patient's caregiver
- Must not already be registered to care for another patient
- Must be at least eighteen (18) years of age
- Have never been convicted of possession or sale of a controlled substance unless such conviction occurred after the effective date of the Act (July 2010) and was related to the possession of marijuana that is authorized under the Act.

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

1. Caregiver 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. Payment of the Application Fee

Mail your completed application and fees to: **DOH – Medical Marijuana**
P.O. Box 37804
Washington, D.C. 20013

Criminal Background Check (CBC)

Schedule a Criminal Background Check through MorphoTrust. Visit the website, http://www.L1ENROLLMENT.com, or call 1-877-783-4187 for information on how to apply. The criminal background check shall include both a local and FBI investigation. The criminal background check fee is separate from the application fee. Out-of-State applicants should refer to the CBC website for additional instructions. **You must begin the application process for your primary registration before scheduling your criminal background check.**

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.

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 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
Caregiver Application Form

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

Caregiver 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 *Note: caregivers must be at least 18 years of age
Residential 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
Patient Name and 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 Date of Birth

Patient's Designated Dispensary	Name of Dispensary Street Zip Code
Patient's 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 (_____) _____ Email Address Phone Number

CAREGIVER 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 within 14 calendar days of receiving notice of a qualifying patient's change in name, address, recommending physician, or designated dispensary, I shall submit the change of information form provided by the Department; surrender my current registration identification card; pay the required fee; and will be issued a new card that reflects the changes.

_____ I understand that within 14 calendar days of receiving notice that the qualifying patient has changed his or her caregiver or that the qualifying patient no longer suffers from a qualifying medical condition or treatment, the Department of Health shall provide me with written notice via US Postal Service certified mail to my address on file with the Department. My caregiver's protection shall expire ten days after delivery of the notice or my failure to claim the notice.

_____ I understand that within 14 calendar days of receiving notice that the qualifying patient has designated a different individual to serve as his/her caregiver or that the qualifying patient no longer suffers from a qualifying medical condition or treatment, I shall surrender my registration card to the Department of Health 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 within 14 calendar days after any change in my name or address, I shall submit the change of information form provided by the Department of Health; surrender my current registration identification card; pay the required fee; and will be issued a new card if applicable.

_____ 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 medical marijuana anywhere other than the qualifying patient's 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 a qualifying patient shall not use medical marijuana at a time or in a location within his/her 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 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.

_____
Caregiver's Signature

_____
Caregiver's Printed Name

_____
Date