

****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 (Minor)*

Applicant- Print Name (First/MI/Last)

NOTE: “minor” means any person under 18 years of age,
but does not include an emancipated minor (22-C DCMR 9900.1)

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
 - 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

Social Security Number

If an applicant or his/her guardian does not have a social security number:

- (1) Submit with the application a sworn affidavit, under penalty of perjury, stating that the applicant or guardian 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 than 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-MINOR

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

<p style="text-align: center;">Patient (Minor) Information</p> <p>*If applicant does not have a Social Security Number, refer to the Application Instructions</p>	<hr/> <table style="width: 100%;"><tr><td style="width: 60%;">First Name</td><td>Middle Initial</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>Last Name</td><td>Suffix (i.e., Jr., Sr., II, III)</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>Social Security number</td><td>Date of Birth</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>Street (PO Box NOT acceptable)</td><td>Apt/Suite</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>City</td><td>State</td><td>Zip Code</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>(_____) Phone Number</td><td>Email Address (if applicable)</td></tr><tr><td colspan="2"><hr/></td></tr></table>	First Name	Middle Initial	<hr/>		Last Name	Suffix (i.e., Jr., Sr., II, III)	<hr/>		Social Security number	Date of Birth	<hr/>		Street (PO Box NOT acceptable)	Apt/Suite	<hr/>		City	State	Zip Code	<hr/>		(_____) Phone Number	Email Address (if applicable)	<hr/>					
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<p style="text-align: center;">Parent or Legal Guardian Information</p> <p>Must be custodial parent or custodial legal guardian to the minor.</p> <p>It is your responsibility to notify the department of all address changes.</p>	<hr/> <table style="width: 100%;"><tr><td style="width: 60%;">First Name</td><td>Middle Initial</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>Last Name</td><td>Suffix (i.e., Jr., Sr., II, III)</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>Social Security number</td><td>Date of Birth</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td><input type="checkbox"/></td><td>Check here if address is same as patient address.</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>Street (PO Box NOT acceptable)</td><td>Apt/Suite</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>City</td><td>State</td><td>Zip Code</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td>(_____) Phone Number</td><td>Email Address</td></tr><tr><td colspan="2"><hr/></td></tr></table>	First Name	Middle Initial	<hr/>		Last Name	Suffix (i.e., Jr., Sr., II, III)	<hr/>		Social Security number	Date of Birth	<hr/>		<input type="checkbox"/>	Check here if address is same as patient address.	<hr/>		Street (PO Box NOT acceptable)	Apt/Suite	<hr/>		City	State	Zip Code	<hr/>		(_____) Phone Number	Email Address	<hr/>	
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<p>Dispensary</p>	<p>_____ Name of Dispensary</p> <p>_____ Street Zip Code</p>
<p>Physician Name and Office Address Information</p>	<p>_____ First Name Middle Initial</p> <p>_____ Last Name Suffix (i.e., Jr., Sr., II, III)</p> <p>_____ Street Apt/Suite</p> <p>_____ City State Zip Code</p> <p>(_____) _____ Phone Number Email Address</p>
<p>Caregiver Name and Address Information</p> <p>Note: Caregivers must be 18 years of age and must register with the Department of Health as a caregiver</p>	<p>_____ First Name Middle Initial</p> <p>_____ Last Name Suffix (i.e., Jr., Sr., II, III)</p> <p>_____ Street Apt/Suite</p> <p>_____ City State Zip Code</p> <p>(_____) _____ Phone Number Email Address</p> <p>_____ Date of Birth</p>



PARENT/LEGAL GUARDIAN 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 the minor's 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 days of any changes to the minor's and/or my name, address, caregiver, recommending physician, or designated dispensary. I shall submit the change of information form provided by the Department; surrender the minor's current registration identification card; notify the minor's 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 the minor no longer suffers from a qualifying medical condition or treatment, I shall surrender the minor's registration card to the Department of Health; notify the minor's 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 the minor experiences theft, loss, or destruction of the minor's 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 the minor 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 the minor shall only possess or administer medical marijuana, or possess or use paraphernalia, obtained from the registered dispensary designated on the minor's registration identification card.
- _____ I understand that the minor or I shall only transport medical marijuana in a container or sealed package bearing the label received from the dispensary.
- _____ I understand that the minor shall not administer or use medical marijuana at a dispensary or cultivation center.
- _____ I understand that the minor shall not administer or use medical marijuana anywhere other than the minor'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 the minor shall not use medical marijuana at a time or in a location within the minor's 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 another minor.
- _____ I understand that the maximum amount of medical marijuana that the minor 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 the minor 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 the neither the minor nor I shall not engage in abusive, intimidating, threatening, or disruptive conduct while on the premises of a dispensary.
- _____ I understand that the neither the minor nor I shall not transfer, share, give, or deliver any unused medical marijuana in the minor's 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 the neither the minor nor I shall grow or cultivate medical marijuana.

_____ I understand that neither the minor nor I shall purchase medical marijuana through street vendors.

_____ I understand that neither the minor nor I shall obtain medical marijuana from other registered qualifying patients or caregivers.

_____ I understand the qualifying medical condition or qualifying medical treatment of the minor.

_____ I understand the potential benefits and potential adverse effects of the use of medical marijuana, in general, and specifically, in the case of the minor.

_____ I consent to the use of medical marijuana for the treatment of the minor's qualifying medical condition or treatment of the side effects of the minor's qualifying treatment.

_____ I consent to, or have designated another adult to, serve as the caregiver for the qualifying patient and that the caregiver will control the acquisition, possession, dosage, and frequency of use of medical marijuana by the qualifying minor patient.

_____ I understand that the Department of Health may deny this 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.

Parent/legal guardian's Printed Name

Parent/ legal guardian's Signature

Date



District of Columbia
Health Regulation & Licensing Administration
Proof of Residency/Identity Form

In order to qualify for the Medical Marijuana Program, the qualifying minor patient and his/her custodial parent or legal guardian must be residents 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.

Applicants must submit at least **TWO (2)** of the following items as proof of the parent or legal guardian's District residency. 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 custodial parent or legal guardian, for the tax period closest in time to the application date
- A property deed for a District of Columbia residence showing the custodial parent or legal guardian as an owner or co-owner
- A valid unexpired lease or rental agreement in the name of the custodial parent or legal guardian 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 minor patient, custodial parent's or legal guardian'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 minor patient, custodial parent or legal guardian evidencing District residency
- A valid unexpired District motor vehicle operator's permit or other official non-driver identification in the name of the minor patient, custodial parent or legal guardian
- A utility bill (excluding telephone bill) from a period within the two (2) months immediately preceding the application date in the name of the custodial parent or legal guardian 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, attach one (1) clear photocopy of U.S., state, or District government-issued photo ID issued to the custodial **parent or legal guardian**, such as a driver's license, as proof of identity. Attach one (1) clear photocopy of U.S., state, or District government-issued photo ID issued to the minor patient if applicable.