Checklist
☐ Patient App. & Fee $100.00 or Fee $25.00 with Proof of Medicaid, SSI or SSDI
☐ Proof of RI Residency
☐ Practitioner Form
☐ Minor Form (If applicable)

FOR OFFICE USE ONLY
Approved By:
Date of Approval:
Registration Number:
Applicant ID #:
Receipt #:
Compassion Center ☐ MCC00001 ☐ MCC00002

Rhode Island
Office of Health Professionals Regulation
Medical Marijauna Program

Room 104 - 3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For
Initial Registration As A

Medical Marijuana Patient

Have you EVER held a registration as a medical marijuana patient in Rhode Island? ☐ **Yes** ☐ **No**

If yes, DO NOT Complete this initial application. Please email mmp@health.ri.gov to obtain the correct application.

Applicant - Print Name (First/MI/Last)

DO NOT REMOVE THIS PAGE FROM THE APPLICATION
Applications are NOT accepted in Person.
All applications must be mailed to the Department

Phone: (401) 222-3752 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 04/16/2014 jcp

REGISTRATION REQUIREMENTS

Requirements for Patients

- Must be a Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a RI Driver's License, RI State ID or a copy of a lease agreement **Note: Your name and current address must appear on the document you submit as proof of residency.**
- Complete and Sign a Patient Form
- Submit a Practitioner Form - Practitioner Form must be completed and signed by one of the following practitioner types: Physician (MD, DO) licensed to practice in RI, MA or CT.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) One hundred dollars ($100.00) **OR** Twenty-five dollars ($25.00) if you are a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI or SSDI. Proof must accompany the application and must say that you are disabled to be eligible for the reduced fee. Verification of your SSI or SSDI eligibility can be obtatined at http://www.ssa.gov.
- May designate up to two (2) caregivers. Only 2 are allowed and can be either a natural person caregiver or compassion center. **NOTE:** There is no fee to add a compassion center if you do so at this time using this form. If you do not add a compassion center at this time and wish to do so in the future, there will be a $25.00 change of information fee.

Requirements for Minor Patients - (Under 18 Years of Age)

- In addition to the requirements listed above, minor patients MUST designate a custodial parent or legal guardian as one of their primary caregivers. **Additionally,** a Minor Form must be completed, signed and submitted along with the Patient Form as described above.

GENERAL INFORMATION

The application process takes 4-6 weeks from the date it is accepted in this office. Applications received that are incomplete will be returned to the patient. **For confidentialtiy purposes information regarding application status will NOT be given over the phone**. Once you are approved you will receive a letter to come in for your photograph.

Rules and Regulations for the program and forms are available on our website at:

http://www.health.ri.gov/healthcare/medicalmarijuana

Changes of Information - (once registered) After you (and your caregiver(s)) receive your registration cards, you can change information by completing a ***"Change Form",*** available online at the above website.

Lost Card (s) There is a twenty-five ($25.00) fee to reprint a new card.

State of Rhode Island - Office of Health Professionals Regulation

"PATIENT FORM"

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

Patient Name

First Name

Middle Name

Last Name

Suffix (i.e., Jr., Sr., II, III)

Date of Birth

Month Day Year

Patients under 18 years of age MUST designate a custodial parent or legal guardian as one of their primary caregivers. **Additionally,** a Minor Form must be completed, signed and submitted along with the Patient Form

Physical Address and Contact Info

It is your responsibility to notify the department of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Mailing Address

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Would you like to be notified of any clinical studies about marijuana's risk or efficacy? ☐ Yes ☐ No

If you check "Yes" you must provide us with a secure confidential email which will be shared with whoever is conducting the study. We will use the email address provided above.

(These studies may be conducted in or outside of Rhode Island)

Practitioner Name and Address Information

Practitioner" means a person who is licensed with authority to prescribe drugs pursuant to chapter 37 of title 5 or a physician licensed with authority to prescribe drugs in Massachusetts or Connecticut.

First Name

Middle Name

Last Name

Suffix (i.e., Jr., Sr., II, III)

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Phone

Patient's Attestation Signature and Date

I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.

If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete this form; attest to; and sign this statement. I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use "Change Form") within ten (10) days of any changes to the information provided.

Patient's Signature Date of Signature

Proxy's Signature (if applicable) Date of Signature

Department of Health

Medical Marijuana Program

Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

PRACTITIONER FORM

Instructions: *Please complete patient information and have your practitioner complete all other sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. Please attach this form to the Patient Application Form and mail the completed forms to the address listed above.*

NOTE: This does NOT constitute a prescription for marijuana

Patient Name, Date of Birth and Phone Number:

Full Name

Birth Month | Birth Day | Birth Year | Phone

Practitioner Name, License Number and Address Information

Full Name

License Number

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

These are the **ONLY** approved qualifying debilitating medical conditions - Check the appropriate box(es):

- ☐ 1. Cancer or the treatment of this condition
- ☐ 2. Glaucoma or the treatment of this condition
- ☐ 3. Positive status for Human Immunodeficiency Virus (HIV) or the treatment of this condition
- ☐ 4. Acquired immune deficiency syndrome (AIDS) or the treatment of this condition
- ☐ 5. Hepatitis C or the treatment of this condition

A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:
(Check all appropriate box(es))

- ☐ 6. Cachexia or wasting syndrome
- ☐ 7. Severe, debilitating, chronic pain-(specify)_____
- ☐ 8. Severe nausea
- ☐ 9. Seizures, including but not limited to those characteristic of epilepsy
- ☐ 10. Severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease
- ☐ 11. Agitation related to Alzheimer's Disease

Comments:

Practitioner" means a person who is licensed with authority to prescribe drugs pursuant to chapter 37 of title 5 or a physician licensed with authority to prescribe drugs in Massachusetts or Connecticut.

I hereby certify that I am a practitioner as defined above. I have a practitioner-patient relationship with the qualifying patient and have completed a full assessment of the patient's medical history. The above-named patient has been diagnosed with a debilitating medical condition as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

Practitioner's Printed Name:_____

Practitioner's Signature: _____ Date of Signature: _____

This form is to be completed by the Attending Practitioner.

Department of Health

Medical Marijuana Program

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MINOR FORM

DECLARATION OF PERSON RESPONSIBLE FOR A MINOR TO PARTICIPATE

Instructions: *Please complete all sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. In addition to the patient application form,* ***this form is required if the patient is a minor*** *(under 18 years of age). Please attach this form to the Patient Application Form and mail the completed forms to the address listed above.*

Patient Name and Information

Full Name

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Date of Birth

Month | Day | Year

Would you like to be notified of any clinical studies about marijuana's risk or efficacy? ☐ **Yes** ☐ **No**
(These studies may be conducted in or outside of Rhode Island.)

I _____, do here by declare:

Custodial Parent or Legal Guardian's Name

1. That I am Custodial Parent or Legal Guardian with the responsibility for health care decisions for:

_____

Patient's Name

2. The patient's attending practitioner has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana;

3. I consent to the use of marijuana by the patient for medical purposes;

4. I agree to serve as the patient's designated primary caregiver; by completing the attached caregiver application and paying the appropriate fee. (see page 6)

5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the patient.

_____ _____

Custodial Parent or Legal Guardian's Signature: Date of Signature:

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation.

Notary Seal

Name of Notary (Print, Type or Stamp):	Signature of Notary:	Notary No./Commission No.:	Commision Expiration:

This form is to be completed by the Custodial Parent or Legal Guardian and is ***required*** *for a Minor Patient.*

Department of Health
Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

Registration Number:
Applicant ID #:
Receipt #:

NATURAL PERSON CAREGIVER - INITIAL APPLICATION

Caregiver information is ALWAYS provided by the Patient.

Caregiver's MUST be twenty-one (21) years of age to apply for a caregiver registration.

Statewide Background Check (BCI) for all caregivers. To obtain a BCI contact your local police department. Caregivers that live in another state must provide a BCI from the state where they live and also include one from Rhode Island. A new BCI is required **each** time a new application is submitted.

Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Two hundred dollars ($200.00) **OR** Twenty-five dollars ($25.00) if the caregiver is a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI or SSDI. Proof must accompany the application to be eligible for the reduced fee.

Each Caregiver may be responsible for up to five (5) patients.

Caregiver Name

First Name

Middle Name

Last Name

Suffix (i.e., Jr., Sr., II, III)

Date of Birth

Month Day Year

Must be at least twenty-one (21) years of age

Mailing Address

It is your responsibility to notify the department of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Phone –

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Patient's Attestation Signature and Date

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Patient's Signature _____ Date of Signature _____

Proxy's Signature (if applicable) _____ Date of Signature _____

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Patient's Signature Date of Signature

Proxy's Signature (if applicable) Date of Signature

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COMPASSION CENTER CAREGIVER - INITIAL APPLICATION

Caregiver information is ALWAYS provided by the Patient.

There is **No Fee to Add Compassion Center(s)** if you do so at this time using this form. If you do not add a compassion center at this time and wish to do so in the future, there will be a $25.00 change of information fee.
Please provide the name(s) of the Center(s) you wish to add and sign and date the form below.

Compassion Center 1 Name	Full Name
Compassion Center 2 Name	Full Name
	Available Centers: **License Number - MCC00001** **THOMAS C SLATER COMPASSION CENTER INC** **1 CORLISS STREET** **PROVIDENCE, RI 02904** **(401) 274-1000** **License Number - MCC00002** **GREENLEAF COMPASSION CENTER** **1637 WEST MAIN ROAD** **PORTSMOUTH, RI 02871** **(401) 293-5987**
Patient's Attestation Signature and Date	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge. If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete this form; attest to; and sign this statement. I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use "Change Form") within ten (10) days of any changes to the information provided. Patient's Signature _____ Date of Signature _____ Proxy's Signature (if applicable) _____ Date of Signature _____