DC HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Health Regulation and Licensing Administration
Division of Medical Marijuana and Integrative Therapy
PATIENT APPLICATION

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

Patient Name ☐ **Initial** ☐ **Renewal**	_____ _____ 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)** ☐ **Nurse Practitioner/ APRN** ☐ **Physician Assistant (PA)** ☐ **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

Application checklist	☐ Two recent (2) Passport photos (2"x2") ☐ Photocopy of U.S., State, or District government-issued photo ID ☐ Application fee (paid by certified check, money order or cashier's check payable to DC Treasurer) ☐ $25.00 (Submit proof of low income) ☐ $100.00 ☐ Two (2) forms of proof of residency ☐ Electronic Healthcare Practitioner Recommendation
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 **All fees are non-refundable**

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APPLICATION INSTRUCTIONS

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

- Completed and signed Patient Application Form, OR completed and submitted online electronic Patient Application (on DC Health website: dchealth.com).
- Two (2) recent Passport-type photographs: two (2) 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.
- Clear photocopy of a U.S., state, or District government-issued photo ID as proof of identity.
- Caregiver Application Form (optional). Note: *required if applying for minor patient*
- Proof of District Residency *(for residency requirements, see page 3)*
- Electronic Healthcare Practitioner Recommendation Form
  - Must be dated no longer than ninety (90) days prior to the application date
- Payment of the Application Fee

Mail your completed application and payment to:

DC HEALTH-Medical Marijuana Program
899 North Capitol Street NE, 2nd FL
Washington, DC 20002

Minors

If patient is under 18, please use the Minor Patient application online at: (https://dchealth.dc.gov/node/822562)

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

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 submitted.

The registration, renewal and replacement fees are as follows:

- Initial registration fee $100.00
- Renewal fee $100.00
- Replacement card fee $90.00

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 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.

899 North Capitol Street NE, 5th Fl, Washington, DC 20002 | P 202-442-5955 | F 202-442-4795 | dchealth.dc.gov

PROOF OF RESIDENCY

In order to qualify for the Medical Marijuana Program, you must be a resident of the District of Columbia. For purposes of this requirement, 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.

To prove District of Columbia residency, applicants must submit at least **TWO (2)** of the following items in the name of the applicant. Check two forms of proof 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 applicant, for the tax period closest in time to the application date

___ A property deed for a District of Columbia residence showing the applicant as an owner or co- owner

___ A valid unexpired lease or rental agreement in the name of the applicant 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 applicant'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 applicant evidencing District residency

___ A valid unexpired District motor vehicle operator's permit or other official non-driver identification in the name of the applicant

___ A utility bill (excluding telephone bill) from a period within the two (2) months immediately preceding the application date in the name of the applicant 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

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