Checklist
☐ Patient App. & Fee $50.00 or Fee $25.00 with Proof of Medicaid, SSI, SSDI or Veterans' Disability
☐ Proof of RI Residency
☐ Practitioner Form
☐ Autism Diagnosis Form (if applicable)
☐ Minor Form (If applicable)

FOR OFFICE USE ONLY	
Approved By:	
Date of Approval:	
Registration Number:	
Applicant ID #: Receipt #:	
Natural PersonCaregiver	☐
Authorized Purchaser	☐

Rhode Island

Center for Professional Licensing

Room 105A - 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 doh.mmp@health.ri.gov to obtain the correct renewal application.

Applicant - Print Name (First/MI/Last)

DO NOT REMOVE PAGES FROM THE APPLICATION

PLEASE SEND ALL PAGES OF THIS APPLICATION WITH PAYMENT
In order to ensure timely delivery and avoid unexpected delays, please send your ORIGINAL completed application by regular US mail.
Photocopies not accepted.

Phone: (401) 222-3752 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1745**

Revised 10/22/2018 jcp

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, vehicle registration, voters registration, correspondence from another state agency with a current date or a current car insurance bill. Note: Your name current address and current date must appear on the document you submit as proof of residency.
- Complete and Sign a Patient Form
- Submit a Practitioner Form - Practitioner Written Certification Form must be completed and signed by one of the following practitioner types: Advanced Practice Nurse, Physician Assistant or Physician (MD, DO) licensed to practice in RI or Physician (MD, DO) licensed to practice in MA or CT.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Fifty dollars ($50.00) **OR** Twenty-five dollars ($25.00) if you are a recipient of Medicaid, Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Federal Railroad Disability benefit. (**NOT Social Security or Medi care**) or Veterans' Disability Photocopy of Medicaid Card, State of Rhode Island "ANCHOR" Medical Assistance Card, a current letter stating that you are a recipient of Medicaid, SSI, SSDI or Veterans' Disability. Proof must accompany the application to be eligible for the reduced fee. Verification of your SSI or SSDI eligibility can be obtatined at http://www.ssa.gov. Note: If the patient's physician provides a written statement indicating the patient is receiving chemotherapy or is Hospice Eligible there is no fee for the patient registration.
- You can designate one (1) caregiver and/or one (1) authorized purchaser. The law requires caregivers and autho rized purchasers to obtain a background check from the National Criminal Information Center (NCIC). In addition, caregivers or authorzied purchasers can be disqualified for a variety of felony charges, not just felony drug convictions. **(See pages 6 and 7 for application fees and instructions for caregivers and authorized purchasers.)**

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 their primary caregiver or authorized purchaser. Additionally, a Minor Form must be completed, signed and submitted along with the Patient Form as described above.

GENERAL INFORMATION

Please send in all pages of this application together with payment and other required documentation to the address listed on the front cover of this application. Do not separate or mail pages separately. Application must be ORIGINAL. Photo-copies will not be accepted.

Please keep a copy of your application. The Department does not make copies of applications for the public.

The application process takes 2-4 weeks from the date it is accepted in this office. Applications received that are incom-plete will be returned to the patient and the processing time will start over. For confidentialtiy purposes information regard-ing application status will NOT be given over the phone. Once you are approved you will receive a letter to come in for your photograph.

If you are intending on growing marijuana in the next year you must contact the Department of Business Regulations at 401-462-9661 or visit their website at **www.dbr.ri.gov**.

Once you are issued the registration you can use any of the three compassion centers in Rhode Island.

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**	**License Number MCC00003** **SUMMIT MEDICAL COMPASSION CENTER INC** **UNIT E2** **380 JEFFERSON BOULEVARD** **WARWICK, RI 02886** **(401) 889-3990**

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 and/or authorized purchaser) receive your registration cards, you can change information by completing a ***"Change Form",*** available online at the above website. If you have any questions regarding patient, caregiver or authorized purchaser applica ions please call 401-222-3752 or email doh.mmp@health.ri.gov.

Lost Card (s) There is a ten-dollar ($10.00) fee to reprint a new card.

State of Rhode Island - Center for Professional Licensing

"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 a caregiver and/or authorized purchaser. **Additionally,** a Minor Form must be completed, signed and submitted along with the Patient Form

Home 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)
If you answer Yes to the question below this Email will be shared with whoever is conducting a study

Mailing Address

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

Second Line Address (Number and Street)

City | State | Zip Code

Are you pregnant or do you plan to become pregnant within the next 12 months? ☐ Yes ☐ No

"This information is requested for data purposes only, and will not be used in the consideration of your application. Answering yes will not result in denial of your application."

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

Practitioner Name and Address Information

Practitioner" means a person who is licensed with authority to prescribe drugs pursuant to chapter 37, chapters 34, 37 and 54 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, Center for Professional Licensing, 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
Center for Professional Licensing
Room 105A - 3 Capitol Hill
Providence, RI 02908-5097
401-222-3752 - www.health.ri.gov/hsr/mmp

PRACTITIONER WRITTEN CERTIFICATION 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):

- ☐ Cancer or the treatment of this condition. Is the patient receiving chemotherapy? ☐ Yes ☐ No
- ☐ Glaucoma or the treatment of this condition
- ☐ Positive status for Human Immunodeficiency Virus (HIV) or the treatment of this condition
- ☐ Acquired immune deficiency syndrome (AIDS) or the treatment of this condition
- ☐ Hepatitis C or the treatment of this condition

Practitoner Signature_____

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

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating, chronic pain-(specify)_____
- ☐ Severe nausea
- ☐ Seizures, including but not limited to those characteristic of epilepsy
- ☐ Severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease
- ☐ Agitation related to Alzheimer's Disease
- ☐ Post Tramatic Stress Disorder (PTSD) - Patient must be 18 years or older
- ☐ Autism Spectrum Disorder - Practitioner must complete Page 5 if this diagnosis is checked.

Comments: **Practitioner" means a person who is licensed with authority to prescribe drugs pursuant to chapter 37, chapters 34, 37 and 54 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.

HOSPICE ONLY: If this patient is eligible for hospice care, the physician must sign here otherwise sign below.
Practitioner Signature (patient eligible for Hospice)_____

Practitioner's Printed Name:_____

Practitioner's Signature:_____ Date of Signature:_____

This form is to be completed by the Attending Practitioner.

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PRACTITIONER WRITTEN CERTIFICATION FORM FOR USE WITH AUTISM SPECTRUM DISORDER DIAGNOSIS

NOTE: A patient who has been diagnosed with Autism Spectrum Disorder based on diagnostic criteria listed in DSM-V – Diagnosis Code 299.00 may qualify for registration as a patient in the Rhode Island Medical Marijuana Program only if the patient presents with one or both the following symptoms. Please check symptom(s) that apply.

☐ Repetition of self-stimulatory behavior of such severity that the physical health of the persons with ASD or others is jeopardized, and/or

☐ Avoidance of others or inability to communicate with others to such severity that the physical health of the person with ASD is jeopardized.

For patients who meet the above diagnostic criteria, the practitioner signing this form is certifying that all of the following treatment considerations and practices have been met:

I have considered FDA-approved medications for this patient, including the off-label use of the pharmaceutic grade forms of pure CBD, prior to initiating medical marijuana therapy. If use of these medications was not implemented, I have documented the reason in the patient's medical record. _____ (Initial here)

If this patient is a minor, I have consulted with a pediatric sub-specialist in child psychiatry, pediatric neurology, or developmental pediatrics prior to signing this form, and the results of that consult is documented in the patient's medical record. _____ (Initial here)

I hereby certify that I will assess this patient (if he/she is a minor) at least three (3) months after initiation of medical marijuana therapy, in consultation with a pediatric sub-specialist in child psychiatry, pediatric neurology, or developmental pediatrics. This assessment and consultation will be documented in the patient's medical record. _____ (Initial here)

I hereby certify that I will discontinue medical marijuana therapy if there is no improvement in the patient's presenting symptom/s as listed above or is there is a worsening of those symptoms. If this is the case, I agree to contact the RIDOH Medical Marijuana Program to withdraw this Certification. (NOTE: Another trial of medical marijuana therapy will be allowed only after the passage of at least three (3) months after the previous trial of medical marijuana has been discontinued.) _____ (Initial here)

Practitioner's Printed Name: _____

Practitioner's Signature _____ DATE:_____

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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 and/or authorized purchaser; by completing the attached caregiver and/or authorized purchaser application and paying the appropriate fee. (see page 6/7)

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 Expirartion:

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Registration Number:
Applicant ID #:
Receipt #:

NATURAL PERSON CAREGIVER - INITIAL APPLICATION

Caregiver information is ALWAYS provided by the Patient.

Caregiver's 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, vehicle registration, voter registration, correspondence from another state agency with a current date or a current car insurance bill. **Note: Your name, current address and current date must appear on the document you submit as proof of residency.**

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

National Criminal Information Center (NCIC). To obtain the background check you must contact your local police department, the department of the attorney general (401-274-4400), or by appointment with the state police (401-444-1000). Please contact them directly with questions and fees related to this process. Attached is a form for your convenience. Caregiver must retain a copy of the records check results in case you wish to become a caregiver for additional patient(s). Your copy will be considered valid for up to 2 years. **Note:** Caregivers can be disqualified for a variety of felony charges and not just felony drug convictions.

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 the caregiver is a recipient of Medicaid, Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Veterans' Disability or Federal Railroad disability benefit. Photocopy of Medicaid Card, State of RI "ANCHOR" Medical Assistance Card, current letter stating that you are a recipient of Medicaid, SSI, SSDI (**NOT Social Security or Medicare**) or Veterans' Disability. Proof must accompany the application to be eligible for the reduced fee. Note: If the patient's physician provides a written statement indicating the patient is Hospice Eligible there is no fee for the caregiver registration. 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

Address

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)

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

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, Center for Professional Licensing, 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
Center for Professional Licensing, Room 105A
3 Capitol Hill, Providence, RI 02908-5097
401-222-3752
www.health.ri.gov/hsr/mmp

Registration Number:
Applicant ID #:
Receipt #:

AUTHORIZED PURCHASER - INITIAL APPLICATION

Authorized Purchaser information is ALWAYS provided by the Patient.

Authorized Purchaser MUST be twenty-one (21) years of age to apply for a registration.

National Criminal Information Center (NCIC). To obtain the background check you must contact your local police department, the department of the attorney general (401-274-4400), or by appointment with the state police (401-444-1000). Please contact them directly with questions and fees related to this process. Attached is a form for your convenience. Authorized Purchaser must retain a copy of the records check results. Your copy will be considered valid for up to 2 years. **Note:** Authorized Purchasers can be disqualified for a variety of felony charges and not just felony drug convictions.

Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**)
Fifty dollars ($50.00)

Each Authorzied Purchaser can only be responsible for one (1) patient at a time.

Authorized Purchaser 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

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

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, Center for Professional Licensing, 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 _____

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NATIONAL CRIMINAL INFORMATION CENTER - (NCIC)

In accordance with Rhode Island General Laws, all applicants for Medical Marijuana Caregiver/Authorized Purchaser must obtain a background check from the National Criminal Information Center (NCIC). As part of this check your fingerprints will be taken. Caregivers and Authorized Purchasers can be disqualified for a variety of felony charges (not just felony drug convictions).

TO: MEDICAL MARIJUANA CAREGIVER/AUTHORIZED PURCHASER

Please obtain a background check (NCIC) from your local police department, the Rhode Island Department of the Attorney General (401-274-4400), or by appointment with the Rhode Island State Police (401-444-1000). Please contact them with questions and fees associated with this process. As part of the NCIC your fingerprints will be taken. Once the check has been processed the results will be sent directly to the Department of Health and a copy will be sent to you.

Please bring this to the law enforcement agency and inform them that you are applying to become a Medical Marijuana Caregiver/Authorized Purchaser so that the results of the check are routed to the correct office.

Medical Marijuana Caregiver/Authorized Purchaser Applicant Name: _____

Medical Marijuana Caregiver/Authorized Purchaser Applicant Date of Birth: _____/ _____/ _____

Month Day Year

Medical Marijuana Caregiver/Authorized Purchaser Applicant Address:

_____

_____

_____

TO: LAW ENFORCEMENT AGENCY

Please provide a National Criminal Information Center Check (NCIC) which shall include fingerprints for the above-named Medical Marijuana Caregiver/Authorized Purchaser applicant. Please send the “Qualify/Does Not Qualify” letter to:

Center for Professional Licensing
Room 105A
Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908
Email: doh.mmp@health.ri.gov