# Medical Marijuana Program
# APPLICATION/RENEWAL
**(Please Print)**

**For application instructions, view page 4.**

This application is for:

☐ Patient Only (Applicant) ☐ Primary Caregiver Only ☐ Patient and Primary Caregiver

**SECTION 1 TO BE COMPLETED BY ALL APPLICANTS.**

Name (last, first, middle initial)

| Mailing address (number, street) | | | Telephone number ( ) |
|---|---|---|---|
| City | State | ZIP code | County of residence |

Additional contact information

Is applicant under 18 years of age? ☐ Yes ☐ No

If yes, complete Section 2 for the parent, legal guardian, or person with legal authority to make medical decisions for minor applicant, unless minor applicant is *(check one)*:

☐ Lawfully emancipated; *or* ☐ Declares self-sufficient minor status or is a minor capable of medical consent

**SECTION 2 TO BE COMPLETED FOR MINOR APPLICANT IDENTIFIED IN SECTION 1.**

| Parent/guardian/other name (last, first, middle initial) | | Telephone number if different from above ( ) | |
|---|---|---|---|
| Mailing address if different from above (number, street) | City | State | ZIP code |

Relation to applicant *(check one)*:

☐ Parent with legal authority to make medical decisions
☐ Legal Guardian
☐ Other person or entity with legal authority to make medical decisions

**SECTION 3 TO BE COMPLETED IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.**

Does the applicant have the capacity to make medical decisions? ☐ Yes ☐ No

If "No," enter the name and address of person acting on the applicant's behalf:

| Name (last, first, middle initial) | | Telephone number ( ) | |
|---|---|---|---|
| Mailing address (number, street) | City | State | ZIP code |

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

**SECTION 4 TO BE COMPLETED BY THE PRIMARY CAREGIVER REQUESTING AN IDENTIFICATION CARD.**

| Name (last, first, middle initial) | | | Date of birth (if less than 18 years of age) |
|---|---|---|---|
| | | | |
| Mailing address (number, street) | | | Telephone number ( ) |
| | | | |
| City | State | ZIP code | County of residence |
| | | | |

Primary Caregiver Duties: *(Document how you consistently assume responsibility for the housing, health, or safety of the applicant.)*

Check your designation as a primary caregiver from the following list:

☐ I am the parent of the applicant or the person entitled to make medical decisions on behalf of the applicant.
☐ I am the designated primary caregiver for only this applicant.
☐ I am the designated primary caregiver for another applicant (qualified patient) in this county.
☐ I am the designated primary caregiver for an applicant (qualified patient) in a different county.

County name: _____

Check one of the two following choices if your status as a primary caregiver is linked to a health related entity:

☐ I am the owner/operator of a clinic pursuant to Chapter 1 (commencing with Section 1200), Division 2 of the Health and Safety (H&S) Code.
☐ I am a clinic/facility/hospice or home health agency employee* designated by the owner/operator to serve as a primary caregiver.

*Check all that apply:*

☐ This health care facility is licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.01 (commencing with Section 1568.01), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.2 (commencing with Section 1569), Division 2 of the H&S Code.
☐ This hospice or home health agency is licensed pursuant to Chapter 8 (commencing with Section 1725), Division 2 of the H&S Code.

* Health and Safety Code, Section 11362.7(d)(1), limits a maximum of three employees that may serve as primary caregivers. **Note:** Include a copy of this page for each caregiver.

**Primary Caregiver Declaration:** I understand and acknowledge my assigned duties as the designated primary caregiver for

_____. I understand that if the applicant's identification card expires, then my primary caregiver
Applicant's name

identification card shall also expire. I agree to return my primary caregiver identification card to this county health department or its designee if this applicant changes primary caregivers. I agree that if I am the owner or operator of a health care facility designated as the primary caregiver of this applicant, that I shall notify this county health department or its designee if a change of primary caregivers is made. I declare under penalty of perjury that the information I provided on this form is true and correct.

_____
Printed name of primary caregiver

_____ _____
Signature of primary caregiver Date

**SECTION 5** **ALL APPLICANTS MUST IDENTIFY THEIR ATTENDING PHYSICIAN.**

| Attending physician name | | | California medical license number |
|---|---|---|---|
| | | | |
| Service mailing address (number, street) | | | Licensed by *(check one)* |
| | | | ☐ Medical Board of California<br>☐ Osteopathic Medical Board of California |
| City | State | ZIP code | |
| | | | |
| Office telephone number<br>( ) | Office fax number<br>( ) | | |

## Notice Required by Civil Code, Section 1798.17

The Civil Code, Section 1798.17, requires that this notice be provided when collecting personal or confidential information from individuals. Providing the individual information and identifying information requested on this form is mandatory. Failure to furnish this information to the administering agency, in order to process your application for a medical marijuana identification card, will result in denial of your application. The information collected will be verified for accuracy to determine eligibility for a medical marijuana identification card. Sections 11362.71 and 11362.715 of the Health and Safety Code authorize the collection and maintenance of the information.

The Compassionate Use Act of 1996 (Act) (Health & Safety Code, Section 11362.5) ensures that patients and their primary caregivers who possess or cultivate marijuana for the personal medical purposes of the patient upon the recommendation of a physician are not subject to California criminal prosecution or sanction. However, the Act does not protect marijuana plants from seizure nor individuals from federal prosecution under the federal Controlled Substances Act. The information that you provide in this application may be released as required by law, judicial order, or subpoena, and could be used in a federal criminal prosecution.

You have the right to access records containing your personal information which are maintained by the county health department, or the county's designee, and the California Department of Public Health.

## Responsibilities

It is my responsibility:

- To notify, within seven days, the county health department or the county's designee of any changes in my attending physician or designated primary caregiver.
- To use my identification card only for the purposes intended by the law.
- To ensure that an authorized medical release of information is on file with my medical provider in order to complete my application.

## Declaration

I have read the notice required by Civil Code, Section 1798.17 and understand my responsibilities as stated above concerning my participation in the Medical Marijuana Program. I confirm to the best of my knowledge the listed duties and information provided by my primary caregiver. I declare under penalty of perjury that the information I provided on and with this application is true and correct.

Print name of applicant or legal representative

Signature of applicant or legal representative

Date

# MEDICAL MARIJUANA PROGRAM APPLICATION/RENEWAL INSTRUCTIONS

**Who may apply?**

This program is voluntary. You may apply with the program if you reside in a California county and your doctor recommends the use of medical marijuana for one or more serious medical conditions you suffer from as specified in number 3 below. It is your option to designate a primary caregiver and apply for their identification card at the time you submit your application.

**INSTRUCTIONS:**

You must complete the *Application/Renewal* form (CDPH 9042) and provide the following information in order to receive an identification card. Submit both the CDPH 9042 and the following information to your county health department (or its designee).

1. Provide a valid government-issued photo identification card (such as a driver's license) issued to you.

   If you are under the age of 18 and lack photographic identification, you may substitute a certified copy of your birth certificate in place of the photo identification. If you designate a primary caregiver on your application form, your primary caregiver must present photographic identification at the same time you submit your application. A primary caregiver may use a certified birth certificate if they are under the age of 18 and lack government-issued photo identification.

2. Provide proof of your county residency with one of the following items:
   - A current rent/mortgage receipt or recent utility bill in your name bearing your current address within the county; or
   - A current California motor vehicle registration in your name bearing your current address within the county

3. Written documentation from your doctor recommending that the use of medical marijuana is appropriate for one or more of the following serious medical conditions you suffer from: Acquired Immune Deficiency Syndrome (AIDS); anorexia; arthritis; cachexia; cancer; chronic pain; glaucoma; migraine; persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis; seizures, including, but not limited to, seizures associated with epilepsy; severe nausea; or any other chronic or persistent medical symptom that either substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 or, if not alleviated, such chronic or persistent medical symptoms may cause serious harm to your safety, or your physical or mental health.

4. Your doctor may use the *Written Documentation of Patient's Medical Records* form (CDPH 9044) to serve as the medical documentation. This form may be obtained from your county or from the California Department of Public Health web site at: http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph9044.pdf

5. The administering agency is required to verify an applicant's medical documentation. It is the applicant's responsibility to ensure that the authorized medical release of information is on file with their medical provider.

6. Contact your local county health department for office locations and identification card fees.

7. Medi-Cal participation at the time of application entitles the applicant to a 50 percent reduction in fees.

8. If you submit an incomplete application and/or fail to provide all the previously mentioned information, your application will be denied and you may be restricted from reapplying for six months.

9. **Application fees are nonrefundable.**