Medicinal Cannabis Control Commission

CHAIR Lisa Brunner VICE CHAIR Regina Murray COMMISSIONER Marcy Hart

Medicinal Cannabis Patient Application

Instructions

This form is for **Patients** and **Primary Caregivers** who need a Medicinal Cannabis Card.

Patient

1. Schedule an appointment with a health care provider (doctor, physician assistant, or advanced practice registered nurse (APRN))

    a. Initial applications need a face-to-face in-person appointment.

    b. Renewal applicants may inquire with their provider's office for available appointments.

2. Submit your application to your health care provider who certifies your condition.

    a. Confirm that the patient is under your care.

    b. Provide the date that you examined the patient for the recertification.

    c. Confirm that you still have a bona fide patient/physician relationship.

3. Fill out the Application. Please have the following documents ready.

    a. Update any other information to the extent it has changed from the previous year (e.g. if you or the patient has a new address).

    b. Valid Driver's License, State ID issued by a state of the United States, or a Valid Passport.

    c. Printed Physician Recommendation.

4. Pay the application fee with a Credit/Debit card/Cashier's Check or Cash. **All fees are non-refundable.**

5. Before submitting your application, make sure all information is correct. If any information changes, contact the Medicinal Cannabis Control Commission.

Primary Caregivers

1. Provide a photo ID.
    a. Valid Driver's License, State ID issued by a state of the United States, or a Valid Passport.

2. Must submit to a background check as required by the White Earth Band of Ojibwe Medicinal Cannabis Code.
        a. This can may take up to 10 days.

A Primary Caregiver must:

a. Notify the Medicinal Cannabis Control Commission (Commission) within 30 business days after any change to the information that the registered qualifying patient was previously required to submit to the Commission, including if the patient becomes an inmate confined in a correctional institution or facility under the supervision of the Department of Corrections.

b. Notify the Commission promptly by telephone and in writing within 10 calendar days following the death of the designated caregiver's registered qualifying patient; and

c. Dispose of all unused medical cannabis by returning the product to the dispensary or Commission.

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Application Form for Medicinal Cannabis Card Information

Section A. Card Holder Information		
Legal First Name	Middle Initial	Legal Last Name
Date of Birth (MM/DD/YY)	Telephone Number	
Current Mailing Address including Apartment/Suite/Lot #		
City	State	Zip Code

Section B: Primary Caregiver Information (required only if primary caregiver)		
Legal First Name	Middle Initial	Legal Last Name
Date of Birth (MM/DD/YY)	Telephone Number	
Current Mailing Address including Apartment/Suite/Lot #		
City	State	Zip Code
Other Names Used by Primary Caregiver (maiden Name(s), etc.)		
Relationship to Patient:		

Section C: Patient/ Primary Caregiver Signature & Date

I attest the information I provided is true and accurate and that I will comply with the requirements of the Medicinal Cannabis Control Commission. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the Medicinal Cannabis Control Commission to print on Medicinal Cannabis Control Commission Cannabis Medical Card.

Signature of Patient: _____

Date: _____

I attest the information I provided is true and accurate and that I will comply with the requirements of the Medicinal Cannabis Control Commission. I agree to serve as the patient's primary caregiver, am at least 21 years old, have no convictions that disqualify me from serving as primary caregiver, and authorize the Medicinal Cannabis Control Commission to use the information provided in this application to perform a criminal background check. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the Medicinal Cannabis Control Commission to print on my Medical Cannabis Card.

Signature of Primary Caregiver: _____

Date: _____

For Official Use Only

Fee Paid_____ Copy of Proof of Identification_____ #ID_____
Physical Form Completed _____ Payment Type: Cash, Credit/Debit Card, Cashier's Check _____
Date Issues: _____ Issued by: _____

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Health Care Provider Form

Section A: Health Care Provider Information (name as it appears on medical license)		
Legal First Name	Middle Initial	Legal Last Name
Current Mailing Address including Apartment/Suite/Lot #		
City	State	Zip Code
Health Care Providers License Number: # _____		
Section B: Patient Information		
Legal First Name	Middle Initial	Legal Last Name
Date of Birth MM/DD/YY		

Section C. Qualifying Medical Conditions	
Category A	**Category B**
☐ Alzheimer's disease ☐ Amyotrophic lateral sclerosis (ALS) ☐ Autism Spectrum Disorder ☐ Cancer* ☐ Chronic motor or vocal tic disorder ☐ Glaucoma ☐ HIV/AIDS ☐ Inflammatory Bowel Disease, Crohn's Disease ☐ Intractable plain ☐ Irritable Bowe Syndrome ☐ Obsessive Compulsive Disorder ☐ Obstructive Sleep Apnea ☐ Post-Traumatic Stress Disorder (PTSD ☐ Seizures (including those characteristic of epilepsy) ☐ Severe and Persistent Muscle Spasms, Including those characteristics of multiple sclerosis (MS) ☐ Sickle Cell Disease ☐ Terminal Illness, with a probable life expectancy of less than one year* ☐ Tourette's Syndrome	If your illness or its treatment produces one or more of the following: ☐ Cachexia or Severe Wasting ☐ Severe or Chronic Pain ☐ Nausea or Severe Vomiting

Section D: Certification, Signature, & Date
By Signing below, I attest that the information entered on this certification is true and accurate. I attest that I am compliant with the Medicinal Cannabis Control Commission and associated administrative rules and have a bona fide physician-patient relationship with this patient. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation. **Signature of Physician:**_____**Date:**_____