



Office of the Marijuana Commissioner
Medical Marijuana Program

MEDICAL MARIJUANA CAREGIVER APPLICATION

Mail Completed Application to: Office of the Marijuana Commissioner ATTN: MMP, Suite 140 417 Federal Street Dover, DE 19901	<input type="checkbox"/> New Caregiver	<input type="checkbox"/> Renewing Caregiver
	Caregiver Application Fee	1 year \$50 2 year \$75 3 year \$100

Print clearly. Incomplete applications may be denied. Application fees are non-refundable. ***Faxed copies of applications will not be accepted.***

CAREGIVER CONTACT INFORMATION

Name: <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	Date of Birth: <i>(Must be 21 or Older)</i>
Address: <i>(Street, Apt. #)</i>		
Address: <i>(City, State, ZIP Code)</i>		
Primary Phone:		
Secondary Phone:		
Email Address: <i>(Optional)</i>		

PATIENT INFORMATION

Name: <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	Date of Birth: <i>(Must be 18 or Older)</i>
Address: <i>(Street, Apt. #)</i>		
Address: <i>(City, State, ZIP Code)</i>		
Primary Phone:		
Patient Relationship to Caregiver:	Patient's Medical Marijuana Registry ID # if known:	

PATIENT AUTHORIZATION

I _____, (patient), hereby authorize the following person to be my designated caregiver for the Delaware Medical Marijuana Program. I authorize this caregiver to assist me in the transportation and storage of my medical marijuana. This person will be responsible for managing my well-being with respect to the use of medical marijuana.

Caregiver's First Name: _____ Last Name: _____

Caregiver's Date of Birth: _____
(Must be 21 or Older) mm/dd/yyyy

This authorization will expire with the expiration of the patient's registry card and will need to be reauthorized with each caregiver renewal.

_____ Patient's Signature	_____ Date
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CAREGIVER'S ATTESTATION STATEMENT

By signing below, the Caregiver certifies that the information on this application is complete, true, and submitted for the purpose of obtaining a State of Delaware Medical Marijuana Caregiver Registry Card. If approved for the Registry Card, the Caregiver acknowledges receipt of and agrees to the terms of the Delaware Medical Marijuana Act, Title 16 of the Delaware Code, Chapter 49A.

_____ <i>initial</i>	I hereby certify that all the information provided on this application is true and accurate to the best of my knowledge.
_____ <i>initial</i>	I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.
_____ <i>initial</i>	I will assist, _____, a qualified medical marijuana patient, with the medical use of marijuana.
_____ <i>initial</i>	I understand that if the patient's registry identification card expires, then my caregiver card for this patient shall also expire.
_____ Caregiver Signature	_____ Date of Signature

CAREGIVER APPLICATION CHECKLIST

<input type="checkbox"/>	Did you initial all four (4) of the Caregiver Attestation Statements and sign on the signature line?
<input type="checkbox"/>	Did the Patient sign the Patient Authorization?
<input type="checkbox"/>	Did you include a legible copy of your Delaware driver's license or state-issued identification?
<input type="checkbox"/>	Did you include your receipt from Delaware State Bureau of Identification (SBI) showing proof that you have requested a statewide and Federal criminal history screening background clearance report to be sent to the Delaware Office of Medical Marijuana (OMM)? Background checks are good for 3 years.
<input type="checkbox"/>	Did you include the non-refundable application fee? Please make check or money order payable to State of Delaware,



Fingerprint Service Code Form

Medical Marijuana Act - USE ONLY

Service Name: Medical Marijuana Act – Medical Marijuana Act

To Schedule your ten-minute fingerprint appointment, simply visit <https://uenroll.identogo.com> and enter the following Service Code

27S2ZG

Service Code is unique to your hiring/licensing agency. Do not use this code for another purpose.
The fee for a state and Federal Criminal Background Check is \$85.00

Please bring one of the identification documents from the list below to your enrollment appointment. Identification must be valid, not expired, and contain a photograph of the applicant.

- Driver's License issued by a State or outlying possession of the U.S.
- Driver's License PERMIT issued by a State or outlying possession of the U.S.
- Driver's License PAPER/TEMPORARY issued by a State or outlying possession of the U.S.
- Enhanced Driver's License (EDL)
- Commercial Driver's License issued by a State or outlying possession of the U.S.
- Commercial Driver's License PERMIT issued by a State or outlying possession of the U.S.
- ID card issued by a federal, state, or local government agency or by a Territory of the United States
- Enhanced Tribal Identification Card (for federally recognized U.S. tribes)
- Department of Defense Common Access Card
- Uniformed Services Identification Card (Form DD-1172-2)
- U.S. Military Identification Card
- U.S. Coastguard Merchant Mariner Card
- Military Dependent's Identification Card
- U.S. Passport
- Foreign passport
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Card/Document (I-766) that contains a photograph
- Canadian Driver's License
- Foreign Driver's License (Mexico and Canada Only)
- U.S. Visa issued by the U.S. Department of Consular Affairs for travel to or within, or residence within, the United States

Name Linking Documents (only needed if name on identification does not match name in registration):

- Original or Certified Copy of a Court Ordered Name Change Document (to include marriage certificates and divorce decrees)



Don't have access to the Internet? You can still schedule an appointment by calling **866.761.8069**.