MEDICAL MARIJUANA PATIENT APPLICATION

Mail Completed Application to: Office of the Marijuana Commissioner ATTN: MMP, Suite 140 417 Federal Street Dover, DE 19901	☐ New Patient	☐ Renewing Patient
	Patient Application Fee	1 year 2 year 3 year $50 $75 $100

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

PATIENT CONTACT INFORMATION

Name: ***(LAST, FIRST, M.I.)*** ☐ M ☐ F ☐ X	**Date of Birth:** *(Must be 18 or Older)*
Address: *(Street)*	
Address: *(P.O. Box, Apt. #)*	
Address: *(City, State, ZIP Code)*	
Primary Phone:	
Secondary Phone:	
Email Address: *(Optional)*	

PATIENT'S ATTESTATION STATEMENT

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

_____

Signature Date

PATIENT APPLICATION CHECKLIST

☐	**Did you include the signed Health Care Practitioner Certification or Self Certification forms. (See page #2)**
☐	**Did you include a legible copy of your Delaware driver's license or state-issued identification?**
☐	**Did you include the non-refundable application fee? Please make check or money order payable to State of Delaware.**

PATIENT'S INSTRUCTIONS: Have your Health Care Practitioner complete this entire section. This section should be submitted with your completed application to the Medical Marijuana Program – partial applications will not be accepted. **The patient application must be received by the Division of Public Health Medical Marijuana Office, within 90 days of the Health Care Practitioner's signature date.**
Faxed and electronic copies will not be accepted.

PATIENTS 65 AND OLDER ARE NOT REQUIRED TO HAVE THIS DOCUMENT SIGNED BY A HEALTH CARE PRACTITIONER. IF YOU ARE SELF-CERTIFYING, PLEASE COMPLETE AND SIGN THE BOTTOM OF THIS PAGE.

PATIENT NAME_____DATE OF BIRTH: _____

HEALTH CARE PRACTITIONER CERTIFICATION & SELF CERTIFICATION

HEALTH CARE PRACTITIONER'S INSTRUCTIONS: Print clearly and provide the medical condition for certification.

CARD TYPE: PLEASE CHECK APPROPRIATE CARD TYPE BELOW.

STANDARD PATIENT CARD	☐	**TERMINAL ILLNESS PATIENT CARD**	☐

HEALTH CARE PRACTITIONER INFORMATION

Name: *(Title, First, MI, Last, Suffix)*		**Medical License Number:**
Address: *(Street)*		**License State:** *(Must be licensed in Delaware)*
Address: *(P.O. Box, Apt. #)*		**License Type:** *(MD, DO, APN, PA)*
Address: *(City, State, ZIP Code)*		
Phone:	**Fax:**	**Email:** *(not required)*
Medical Specialty: *(Oncology, Neurology, etc)*		

Health Care Practitioner Identified Medical Condition(s) for Adult Patients:
(Please identify medical condition below)

_____ _____
Health Care Practitioner's Signature (no signature stamps accepted) Date

Delaware residents 65(+) may self-certify – Please identify your medical condition(s):

- Self-certification. I will use medical marijuana for the treatment of a medical condition or for the side effects of a medical treatment. I understand my rights and obligations as set forth by the Delaware Medical Marijuana Program and agree to these requirements. I certify under penalty of perjury that the foregoing is true and correct.

Medical Condition(s) For Self-Certification **(Please identify medical condition below)**

_____ _____
Patient Signature Date