DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Medical Marijuana

*For the most current information regarding this application, medical marijuana laws in the State of Delaware, and more see the official website:*
*http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html*

# MEDICAL MARIJUANA PATIENT APPLICATION

| Mail Completed Application to:<br>Delaware Division of Public Health<br>ATTN: MMP, Suite 140<br>417 Federal Street<br>Dover, DE 19901 | ☐ New Patient | ☐ Renewing Patient |
|---|---|---|
| | Patient 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***.

## 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:** | ☐ Check this box if a confidential message may be left at this number. |
| **Secondary Phone:** | ☐ Check this box if a confidential message may be left at this number. |
| **Email Address:** *(Optional)* | ☐ Check this box if confidential information may be shared by email. |

## 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

| _____<br>Patient Signature | _____<br>Date of Signature |
|---|---|

**Delaware residence 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.
- Omit the Health Care Practitioner Certification of this application and identify your medical condition(s) below.

## Medical Condition(s) For Self-Certification

## VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested - check the items that apply. It is the policy of the State of Delaware to assure equal and fair treatment in all aspects of healthcare for all Delaware residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected. De-identified patient information is used for research purposes. Aggregate, de-identified patient information can be published and shared with third parties.

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried Partnership

**Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

**Race:**
☐ Caucasian / White ☐ African American / Black
☐ Asian ☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander ☐ Other _____

**Language:**
**How well do you speak English?**
☐ Very Well ☐ Well ☐ Not Well ☐ Not at All
**Do you speak another language other than English at home?**
☐ No ☐ Yes, Spanish ☐ Yes, not Spanish, specify _____

**Veteran Status:**
**Are you a United States veteran?**
☐ No ☐ Yes

**Citizenship:**
**Are you a citizen or lawful resident of the United States of America?**
☐ No ☐ Yes

**Education:**
**What is your highest level of education completed?**
☐ Some High School Completed ☐ Technical School
☐ High School Diploma / GED ☐ University / 4-Yr College
☐ Community College / 2-Yr Degree ☐ Master Program or Above
**Are you currently enrolled in school?**
☐ No ☐ Yes, please specify: _____

**Employment:**
**Are you currently employed?**
☐ No ☐ Yes, part-time ☐ Yes, full-time
**What is your current occupation?** _____

**Income:**
**What is your annual household income?**
☐ Less than $19,999 ☐ $60,000 to $79,999
☐ $20,000 to $39,999 ☐ $80,000 to $99,999
☐ $40,000 to $59,999 ☐ $100,000 or above

**Public Assistance:**
**Are you currently enrolled in a public assistance program such as food supplement program or any other?**
☐ No ☐ Yes, please specify: _____

## HEALTH CARE PRACTITIONER CERTIFICATION

**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.

**NOTE: THIS DOES NOT CONSTITUTE A PRESCRIPTION FOR MARIJUANA.**

**HEALTH CARE PRACTITIONER'S INSTRUCTIONS: Print clearly and answer all of the questions with information in the patient's medical record.**

**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:

**HEALTH CARE PRACTITIONER CERTIFICATION (CONTINUED)**

## HEALTH CARE PRACTITIONER ATTESTATION

I _____, (Health Care Practitioner), hereby certify that I am a Health Care Practitioner duly licensed to practice medicine. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's medical condition or symptoms associated with the medical 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.

I have established a bona fide Health Care Practitioner-patient relationship

I completed an assessment of the patient's current medical condition, including presenting symptoms related to the medical condition I diagnosed or confirmed in accordance with Title 16, Chapter 49A of the Delaware Code (4902A(3).

I have completed an assessment of the patient's medical history, including medical records from other treating Health Care Practitioners for their medical condition. I have established a medical record of the patient with regards to the medical condition, continued treatment under my care, and will document follow-up to determine efficacy of the medical marijuana treatment.

This qualifying patient is under my care, either for primary care or the medical condition listed on this form

I attest that the information provide in this written certification is true and correct.

_____ _____

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

**Comments: Provide any additional information that would be useful in assessing this patient's application to the Delaware Medical Marijuana Program**.

## PATIENT RELEASE OF MEDICAL INFORMATION

**PATIENT'S INSTRUCTIONS:** Complete and sign the following release statement. This form will allow the Medical Marijuana Program staff to verify information with the certifying Health Care Practitioner(s) relating to your qualified medical condition. This form must be submitted with your patient enrollment application. If this form is omitted, your application will be considered incomplete and will be denied. Faxed and electronic copies will not be accepted.

### PATIENT RELEASE REQUEST

I _____, (patient), hereby authorize the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH), Medical Marijuana Program (MMP) to discuss my medical condition, including treatment records, test results, and evaluations specific to _____, (patient's qualifying condition), with my certifying medical provider:

_____, (Health Care Practitioner's full name),

I understand that I may revoke this release at any time. I also understand that if I wish to revoke this authorization, I must do so in writing to the Delaware Medical Marijuana Program, and that revocation may result in the inability of the program to certify me as a Medical Marijuana Program participant. Additionally, I understand that the revocation will not apply to the information that has already been released in response to this authorization.

This information disclosed pursuant to the authorization is subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I understand that this disclosure is voluntary and that signing this form in not necessary in order to receive treatment from the Delaware Department of Health and Social Services. This release is required; however, to verify my eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my enrollment status with law enforcement; but only for the purpose of verifying that a person is lawfully enrolled in the Medical Marijuana Program, or in the event that the Medical Marijuana Program administrator or designee has reason to believe that a qualified patient-applicant may have violated an applicable law.

This authorization will expire (1-3) years from the date signed below unless a different expiration date, less than one (1) year, is specified here: _____.

_____ Patient's Signature

_____ Date

### PATIENT APPLICATION CHECKLIST

| | |
|---|---|
| ☐ | **Did you include the Health Care Practitioner Certification forms completed and signed by your Health Care Practitioner? (Pages 3-4)** |
| ☐ | **Did you sign the Release of Medical Information form? (Page 5)** |
| ☐ | **Did you include a legible copy of your Delaware driver's license or state-issued identification?** |
| ☐ | **Did you include the non-refundable application fee or your signed Low Income Charge Request form with supporting documentation? Low-Income Charge Request are valid for ONE YEAR CARDS ONLY. Please make check or money order payable to State of Delaware.** |

## FEE TABLE:

| | | 1 year | 2 year | 3 year |
|---|---|---|---|---|
| Patient Application Fee (registration effective from issue date) | $ | 50 | 75 | 100 |
| Pediatric Patient Application Fee (includes parent/guardian fees) | $ | 50 | 75 | 100 |
| Caregiver Application Fee | $ | 50 | 75 | 100 |
| Card Re-Issue Fee | $ | 20 | 0 | 0 |