**APPLICATION FOR A WAIVER**

**105 CMR 725.700**

**INSTRUCTIONS**

This application form is to be completed by an individual or entity that wishes to apply for a waiver from full compliance with the regulation implementing the Humanitarian Medical Use of Marijuana Act, Ch. 369 of the Acts of 2012 (“requestor”).

Pursuant to 105 CMR 725.700, the Commissioner of the Department of Public Health may waive the applicability of one or more of requirements imposed by 105 CMR 725.000 upon the finding that:

1. Compliance would cause undue hardship to the requestor;
2. If applicable, the requestor’s non-compliance does not jeopardize the health or safety of any patient or the public;
3. If applicable, the requestor has instituted compensating features that are acceptable to the Department; and
4. The requestor provides to the Commissioner written documentation supporting its request for a waiver.

Waiver requestors must identify themselves and their status, cite with specificity the regulation(s) that they want a waiver from, and demonstrate how they meet the requirements of the waiver regulation, 105 CMR 725.700.

Unless indicated otherwise, all requests must be typed into the application form. Handwritten requests will not be accepted. Any attachments should be labelled or marked so as to identify the question to which it relates.

Each submitted application must be a complete, collated request printed single-sided, and secured with a paper clip or binder clip (no ring binders, spiral binding, staples, or folders).

Mail or hand-deliver the Waiver Application Form, with any attachments, to:

Department of Public Health

Medical Use of Marijuana Program

Waiver Application

99 Chauncy Street, 11th Floor

Boston, MA 02111

**REVIEW**

Applications are reviewed in the order they are received.

After a completed application is received by the Department of Public Health (“Department”), the Department will review the information and will contact the requestor if clarifications or updates to the submitted application are needed. The Department will notify the requestor whether it has met the standards necessary to receive the requested waiver*.*

**PUBLIC RECORDS**

Please note that all application responses, including all attachments, will be subject to release pursuant to a public records request, as redacted pursuant to the requirements at M.G.L. c. 4, § 7(26).

**QUESTIONS**

If additional information is needed regarding the waiver application process, please contact the Medical Use of Marijuana Program at 617-660-5370 or [RMDcompliance@state.ma.us](mailto:RMDcompliance@state.ma.us).

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| **SECTION A: REQUESTOR STATUS**  **(REQUIRED)** |
| Indicate with an “X” the status of the requestor. If “other,” provide an explanation:  Registered Marijuana Dispensary Applicant  Registered Marijuana Dispensary  Dispensary Agent  Qualifying Patient  Personal Caregiver  Caregiving Institution  Institutional Caregiver  Independent Testing Laboratory  Laboratory Agent  Other: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SECTION B: REQUESTOR INFORMATION**  **(REQUIRED)** | | | | |
| 1. Name of Requestor (if requestor is an entity, indicate legal name of entity): | | | | |
| 2. Registration number (if applicable): | | | | |
| 3. Organization name (if applicable): | 4. Requestor date of birth (if requestor is an individual) | | | |
| 5. Requestor telephone number:  ( ) | 6. Gender (if the requestor is an individual):  Male  Female | | | |
| 7. Requestor mailing address 1: | 8. Requestor mailing address 2 (if applicable): | | | |
| 9. City: | 10. State: | | 11. Zip code: | |
| 12. Requestor residential address 1 (if requestor is an individual): | 13. Requestor residential address 2 (if applicable): | | | |
| 14. City: | 15. State: | | 16. Zip code: | |
| **SECTION C: REQUESTOR CONTACT PERSON INFORMATION**  **(REQUIRED)** | | | | |
| 17. Last name of contact person: | | 18. First name of contact person: | | |
| 19. Relationship to Requestor: | | | | |
| 20. Phone number of contact person:  ( ) | | 21. Alternate phone number of contact person:  ( ) | | |
| 22. Contact person mailing address 1: | | 23. Contact person mailing address 2 (if applicable): | | |
| 24. City: | | 25. State: | | 26. Zip code: |
| 27. Email address of contact person: | | | | |

**SECTION D. GROUNDS FOR A WAIVER REQUEST**

1. I, the undersigned, request a waiver from the following provision(s) of the regulation, 105 CMR 725.000, et seq.:



2. Explain how compliance will cause undue hardship to the requestor: 

1. If applicable, explain how non-compliance with the regulation at issue does not jeopardize the health or safety of any patient or the public:



1. If applicable, explain how the requestor has instituted compensating features that are acceptable to the Department:



**ATTESTATION**

Signed under the pains and penalties of perjury, I, the authorized signatory for the Requestor, agree and attest that all information included in this application is complete and accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click here to enter a date.

Signature of Authorized Signatory Date Signed



Print Name of Authorized Signatory



Title of Authorized Signatory (if applicable)