

## Medical Use of Marijuana Program: Patient Registration Form

Registering online with the Medical Use of Marijuana Program (Program) is the fastest and most convenient way to register to possess marijuana for medical purposes. This paper registration form is for use by patients who do not have access to the internet and are unable to register online.

**In order to register as a patient with the Program, you must first obtain a certification from a Medical Use of Marijuana Program registered clinician/health care provider.**

After your Medical Use of Marijuana Program registered clinician/health care provider issues you a certification, complete and mail in the attached registration form along with the required documents listed below. Following the completion of the registration process, you will receive your Program ID Card in the mail.

### Preparing for Registration

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Before filling out the attached registration form, you will need to gather the following items:

- Your **PIN**, as given to you by your Medical Use of Marijuana Program registered clinician/health care provider, and emailed to you by the Program, after you are certified;
- A copy of a valid form of identification (ID), as explained below; *and*
- A photograph of yourself, as explained below.

### Valid Form of ID

*Valid forms of ID include:*

- Massachusetts driver's license;
- Massachusetts ID card (with a photograph of yourself);
- U.S. passport and another document that proves your Massachusetts residency; *or*
- U.S. military ID and another document that proves your Massachusetts residency.



**If submitting a passport or U.S. military ID:**

If you submit a passport or U.S. military ID as your valid form of ID, you must also submit a document that proves your primary residence (as outlined below). Also, the name and address you submit to the Program must match the name and address on the document that you submit to prove your primary residence.

*Submit one of the following, which proves your primary residence:*

- Utility bill (gas, electric, telephone, cable, or heating oil), that is less than 60 days old and must contain your name and address;
- Your current motor vehicle registration card with your current address;
- Tuition bill with a due date of less than six (6) months ago and addressed to your current address;
- Car insurance policy or bill that is less than 60 days old;
- Home mortgage, lease, or loan contracts dated within six (6) months of today with your name, address, and signature;
- Certified U.S. Marriage Certificate dated within the past six (6) months;
- Property tax or excise tax bill for the current year with your name and address;
- First-class mail dated less than 60 days old from any federal or state agency that displays your name and address; *or*
- Current state-issued Professional License with your address.

**Photograph of Yourself**

This photo will be placed on your Program ID Card.

*Your photo must be:*

- In color;
- A square photo in portrait/upright format;
- Taken in front of a plain white or off-white background;
- Taken within the last six (6) months to reflect what you look like now;
- Showing only your head and the top of your shoulders;
- Taken looking directly at the camera held at eye level;
- Taken without smiling, with both eyes open, and without eyewear; *and*
- Taken without any item that covers your face or head, except for religious purposes.

A passport photo meets these requirements and can be obtained at any location that issues passport photos, such as a pharmacy, the post office, or a camera store.

## Submitting Your Registration Form

Mail your:

- Completed registration form;
- **Copy** of a valid form of ID (and **copy** of a document proving your Massachusetts residency, if applicable); *and*
- Photograph

To:

**Cannabis Control Commission  
Medical Use of Marijuana Program  
Worcester Union Station  
2 Washington Square  
Worcester, MA 01604**

After submitting your registration form, you will be notified regarding the status of your registration. If an email address was provided, you will receive a notification regarding the status of your registration via email. Following completion of the registration process, you will receive your Program ID Card in the mail.

## Selecting a Personal Caregiver

*In order to select a personal caregiver, please follow these steps:*

- **STEP 1:** Complete Section B of the registration form.
- **STEP 2:** After you submit your registration form, the Program will email you a **PIN** to give to your personal caregiver in order for them to register.
- **STEP 3:** **Provide the PIN to your personal caregiver** and direct them to register with the Program. Your personal caregiver must use this PIN in order to register.
- **STEP 4:** After your personal caregiver has submitted an application for registration, call the Program at 833-869-6820 to verify that this individual may be linked to you as your personal caregiver. After you provide verification, the Program will process your personal caregiver's application for registration. If approved for registration, your personal caregiver may assist you with your medical use of marijuana.

## **Other Important Information About Registration**

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Patients must maintain an active certification from their Medical Use of Marijuana Program registered clinician/health care provider and an active registration with the Program in order to be protected for medical use of marijuana under Massachusetts law.

### **Program ID Card**

You must carry your Program ID Card **at all times** while you are in possession of marijuana for medical use.

Program ID Cards are issued annually. You are required to renew your registration with the Program every year in order to remain active.

Notify the Program within **five (5) business days** after discovering that your Program ID Card is lost, stolen, or destroyed by calling 833-869-6820.

There is a \$10 fee to replace a Program ID Card.

**PATIENT REGISTRATION FORM** (Please Print)

**SECTION A: PATIENT INFORMATION (REQUIRED)**

The name and address on this form must match the name and address on your valid form of identification (ID), or document that proves your Massachusetts residency.

1. PIN or registration number: \_\_\_\_\_ 2. Last 4 digits of Social Security Number: \_\_\_\_\_

Full name: \_\_\_\_\_  
3. Last 4. First M.I.

5. Date of birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 6. Phone: ( \_\_\_\_ ) \_\_\_\_\_

7. Email : \_\_\_\_\_ 8. Gender MALE FEMALE

9. I choose to be communicated with via: U.S. Mail  Email  10. Mother's maiden last name: \_\_\_\_\_

**RESIDENTIAL ADDRESS OF PATIENT (REQUIRED)**

Address: \_\_\_\_\_  
11a. Residential address of patient 11b. Apt. or suite number  
\_\_\_\_\_  
12. City 13. State 14. ZIP code  
MA

**MAILING ADDRESS OF PATIENT (IF DIFFERENT FROM RESIDENTIAL ADDRESS)**

Address: \_\_\_\_\_  
15a. Mailing address of patient 15b. Apt. or suite number  
\_\_\_\_\_  
16. City 17. State 18. ZIP Code  
MA

**VALID FORM OF ID (REQUIRED)**

Please note that if Passport or Military ID is selected, you will need to submit another document that proves your primary residence.

19. I am submitting a copy of the following valid form of ID:

Driver's License

ID Card

U.S. Passport

U.S. Military ID

\_\_\_\_\_  
20. Number on valid form  
of ID

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
21. Expiration date of valid form of  
ID (mm/dd/yyyy)

**SECTION B: PERSONAL CAREGIVER DESIGNATION (OPTIONAL)**

If you do not have a personal caregiver, please skip to Section C.

Please indicate your personal caregiver's name and their relationship to you.

22. I would like to designate the following individual(s) as the patient's personal caregiver(s), I would like the Cannabis Control Commission to generate a PIN on my behalf to allow the personal caregiver(s) to register, and understand that I am responsible for giving the PIN to my personal caregiver(s) once I receive it:

**CAREGIVER 1**

Full name: \_\_\_\_\_  
a. Last b. First

c. Personal caregiver relation to patient: Immediate family member Other  
  \_\_\_\_\_

**CAREGIVER 2**

Full name: \_\_\_\_\_  
a. Last b. First

c. Personal caregiver relation to patient: Immediate family member Other  
  \_\_\_\_\_

**SECTION C: PATIENT ATTESTATIONS (REQUIRED)**

Read the attestations below and check the box to attest that you understand and agree with the attestations.

- I have submitted all the required information to the best of my abilities and have not made any false representations.
- I attest that I will only engage in the medical use of marijuana that is consistent with my certifying physician’s recommendations.
- I will not engage in the diversion of marijuana purchased for medical use.
- I understand that the protections conferred by Chapter 369 of the Acts of 2012, An Act for the Humanitarian Medical Use of Marijuana, for possession of marijuana for medical use are applicable only within Massachusetts.
- I understand that nothing in Massachusetts law or the Cannabis Control Commission regulations, 935 CMR 501.000, purports to give immunity under federal law, or poses an obstacle to federal enforcement of federal law.
- I understand that I must carry my Program ID at all times while in possession of marijuana for medical use.
- I understand that I am responsible for notifying the Medical Use of Marijuana Program within five business days (by calling 833-869-6820) after any change to the information that I have submitted to the Cannabis Control Commission, or after I discover that my Program ID Card has been lost, stolen, or destroyed.
- I understand that, if available, a copy of my photo in the Registry of Motor Vehicles database will be transferred into the Medical Use of Marijuana Program Online System for recordkeeping purposes.
- I understand that the photo in the Medical Use of Marijuana Program Online System database will be placed on my Program ID Card for identification purposes.
- I authorize the Medical Use of Marijuana Program to release to the Medical Marijuana Treatment Centers, for the purpose of dispensing marijuana for medical use, my registration information, including: my name; the term of my certification; the dispensing period; the amount a Medical Marijuana Treatment Center is authorized to dispense to me or my personal caregiver; whether I am authorized to cultivate; the form of identification used for registration, its number (if applicable) and its expiration date; the name of my certifying medical provider, his/her business address and phone number; and my dispensing history.
- I understand that by providing an email address to the Medical Use of Marijuana Program (Program), the Program will use the email address that I have provided to communicate with me. These emails will be used to send me information about the Program and the online registration system and may discuss marijuana or the medical use of marijuana. Examples of this information include, but are not limited to, general program updates, registration status, or information required from you by the Program.
- I understand that email is not entirely secure or private, and that unauthorized people may be able to intercept, read, and possibly change email I send to or receive from the Medical Use of Marijuana Program (Program). The Program recommends that I protect my email account, password, and computer against access by unauthorized people and that I install and maintain virus protection software on my personal computer. I also understand that since emails can be copied, printed, and forwarded by people to whom I send emails, I should be careful regarding sharing emails.
- I understand that I do not have to agree to provide an email address in order to communicate with the Medical Use of Marijuana Program (Program). If I do not want to receive emails from the Program, I must email the Program at MedicalMarijuana@state.ma.us. If I decide at any time I no longer want to receive emails from the Program, I must email the Program at MedicalMarijuana@state.ma.us. I understand that if I do not want to receive emails or later change my mind about receiving emails, the Program will communicate with me through U.S. mail.

**By checking the box, I attest that I understand and agree with each of the Attestations in Section C.**

I hereby certify that the above information is correct and complete.

23. Patient signature: \_\_\_\_\_

24. Date signed (mm/dd/yyyy): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_