



Illinois Medical Cannabis Patient Program
Application for Registry Identification Card
Persons Diagnosed with Terminal Illness
Valid for Six (6) Months Only

QUALIFYING PATIENT INFORMATION

Social Security Number (###-##-####)		Driver's License Number	Driver's License State	No Driver's License <input type="checkbox"/>
First Name	Middle Name	Last Name		
Home Address			Apartment or Suite Number	
City	County	State IL	ZIP Code	
Telephone Number (###-###-####)		E-mail Address		
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Are you an active duty law enforcement officer, correctional officer, correctional probation officer or firefighter? (If yes, this will result in a denial.) <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a school bus permit or a Commercial Driver's License? (If yes, this will result in a denial if not removed.) <input type="checkbox"/> Yes <input type="checkbox"/> No		

PHOTOGRAPH OF QUALIFYING PATIENT OVER AGE 18

(No photograph is required for patients under age 18 who are diagnosed with terminal illness)

Attach a current digital passport-sized picture here (use tape on the back of the picture)



Photograph Requirements

- Taken in the last 6 months
- Taken against a plain, white, or off-white background or backdrop
- In natural color (Do not use a filter)
- Full-face view directly facing the camera with a neutral facial expression and both eyes open
- At least 2 inches by 2 inches in size

It is recommended you use a passport photo vendor to ensure the photograph meets these requirements.

Contact the Division of Medical Cannabis if a photograph is in violation of or contradictory to the qualifying patient's religious convictions.

This application was prepared by:

PRINT/TYPE PREPARER'S NAME

DATE (mm/dd/yyyy)

FIRM OR ORGANIZATION NAME

PHONE NUMBER



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CERTIFICATIONS

I certify the information provided in this application is true and accurate to the best of my knowledge.

Submission of false, misleading or inaccurate information in connection with this application is grounds for revocation of my Illinois Medical Cannabis Qualifying Patient Registry Identification Card and other administrative, civil or criminal penalties.

I understand this application and the associated registry identification card, if approved, are only valid for six months from the date issued and if I no longer have a diagnosis of terminal illness after six months, I shall submit a full application, on the appropriate forms, along with all associated fees for a registry application card.

I additionally certify that I have been given actual Notice and understand that, notwithstanding the Compassionate Use of Medical Cannabis Patient Program Act (Act):

- (i) cannabis is a prohibited Schedule I controlled substance under federal law;
- (ii) participation in the program is permitted only to the extent provided by the strict requirements of the Act;
- (iii) any activity not sanctioned by the Act may be a violation of state or federal law and could result in arrest, conviction, or incarceration;
- (iv) distributing cannabis under the Act, unless done through a federally-approved research program, is a violation of federal law;
- (v) distributing cannabis in any capacity, except through a federally-approved research program, may be a violation of state or federal law and could result in arrest, conviction or incarceration;
- (vi) use of medical cannabis, or possessing a medical cannabis patient or caregiver registry card, may affect an individual's ability to receive or retain federal or state licensure in other areas;
- (vii) use of medical cannabis or possessing a medical cannabis patient or caregiver registry card, in tandem with other conduct, may be a violation of state or federal law and could result in arrest, conviction or incarceration;
- (viii) participation in the Medical Cannabis Patient Program does not authorize any person to violate federal law or state law;
- (ix) the Act does not provide any immunity from or affirmative defense to arrest or prosecution under federal law or state law, other than as set out in 410 ILCS 130/25; and
- (x) applicants shall indemnify, hold harmless, and defend the state of Illinois for any and all civil or criminal penalties resulting from participation in the program.

SIGNATURE OF QUALIFYING PATIENT

DATE (mm/dd/yyyy)

MEDICAL CANNABIS DISPENSARY SELECTION (Answer Required)

Name and Address of Dispensary
Dispensary District

You must select a dispensary to enter and purchase medical cannabis. The list of dispensaries currently licensed by the state of Illinois may be viewed at <http://www.idfpr.com/Forms/MC/ListofLicensedDispensaries.pdf>.



Illinois Medical Cannabis Patient Program
Health Care Professional Confirmation of Diagnosis of Terminal Illness

*** This section to be completed by the Qualifying Patient's health care professional ***

Do Not Complete for Veterans Receiving Medical Care at a VA Facility

HEALTH CARE PROFESSIONAL INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

Health Care Professional First Name		Health Care Professional Middle Name		Health Care Professional Last Name	
Office Address (Location where the Qualifying Patient's Medical Examination was conducted)					
Suite #		City		State IL	ZIP Code
Office Telephone Number (###-###-####)			E-mail Address		
Illinois License Number			Illinois Controlled Substances License Number (last two digits)		
Length of time patient has been under your care (years/months)			Date of in-person medical examination relating to this certification (mm/dd/yyyy)		

ATTESTATIONS

I _____ (the health care professional), have made a diagnosis of terminal illness of _____ (insert name of disease or illness) with a life expectancy of six (6) months or fewer for the qualifying patient _____ (date of birth) _____, and by my signature below certify the following:

1. I have established a bona-fide relationship with the qualifying patient applicant. The qualifying patient is under my care, either for his/her primary care or for his/her terminal illness, as specified on this form. This bona-fide relationship is not limited to the diagnosis of terminal illness for the patient to use medical cannabis or a consultation simply for that purpose.
2. I have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I understand the Illinois Department of Public Health may request additional confirmation of the assessment(s) performed for this qualifying patient's terminal illness.
3. I have completed an assessment of the qualifying patient's medical history, including the review of medical records from other treating health care professionals from the previous 12 months. I have established a medical record for the qualifying patient related to the patient's terminal illness and continued treatment under my care.

I _____ (the health care professional), hereby certify I am duly licensed to practice medicine in the state of Illinois. The qualifying patient has the terminal illness specified, and the patient is under my management for the terminal illness and/or their primary care. I attest the information provided in this written certification is true and correct.

Health Care Professional signature (no stamps accepted) – Sign in blue ink only

Date of signature (mm/dd/yyyy)



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DESIGNATED CAREGIVER INFORMATION - Must be at least 21 years old

Social Security Number (###-##-####)	Driver's License Number	Driver's License State	No Driver's License <input type="checkbox"/>
First Name	Middle Name	Last Name	
Home Address		Apartment or Suite Number	
City	County	State IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address (required for online applicants)		
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		

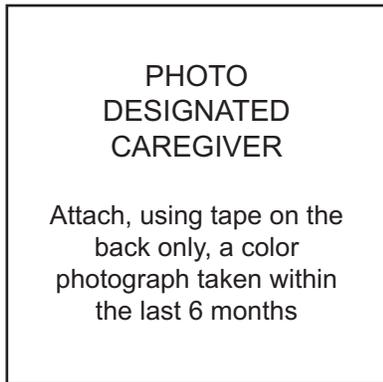
Name of Qualifying Patient _____ **Patient's Date of Birth (mm/dd/yyyy)** _____

If this application is for a person under age 18 who has been diagnosed with a terminal illness, a second designated caregiver can be added by making a copy of pages 4 and 5 and completing the requested information for the second designated caregiver.

Did you attach a color copy of your Illinois Driver's License or Illinois State ID?

DESIGNATED CAREGIVER PHOTOGRAPH

Attach a current digital passport-sized picture here (use tape on the back of the picture)



Photograph Requirements

- Taken in the last 6 months
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SIGNATURE OF QUALIFYING PATIENT

DATE (mm/dd/yyyy)



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DESIGNATED CAREGIVER ATTESTATIONS

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- (ii) participation in the program is permitted only to the extent provided by the strict requirements of the Act;
- (iii) any activity not sanctioned by the Act may be a violation of state or federal law and could result in arrest, conviction, or incarceration;
- (iv) growing, distributing, or possessing cannabis under the Act, unless done through a federally-approved research program, is a violation of federal law;
- (v) growing, distributing, or possessing cannabis in any capacity, except through a federally-approved research program, may be a violation of state or federal law and could result in arrest, conviction or incarceration;
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- (ix) the Act does not provide any immunity from or affirmative defense to arrest or prosecution under federal law or state law, other than as set out in 410 ILCS 130/25; and
- (x) applicants shall indemnify, hold harmless, and defend the state of Illinois for any and all civil or criminal penalties resulting from participation in the program.

SIGNATURE OF DESIGNATED CAREGIVER

DATE (mm/dd/yyyy)

Mail the application and required documents to:

Illinois Department of Public Health
Division of Medical Cannabis
535 West Jefferson Street
Springfield, Illinois 62761-0001

Questions? Contact the Division of Medical Cannabis at 855-636-3688 or DPH.MedicalCannabis@Illinois.gov.



Illinois Medical Cannabis Patient Program Application for Registry Identification Card Veterans Receiving Medical Services at a VA Facility

***** DO NOT COMPLETE THIS FORM IF YOU ARE NOT A VETERAN *****

Veterans receiving health care at a VA facility do not need to provide the health care professional confirmation of diagnosis of terminal illness on page 3, but must instead provide the following information found on My HealthVet.

- Medical records from the VA facility for the last 12 months.
 - VA appointments
 - VA medication history
 - VA problem list
 - VA admissions and discharges
 - VA progress notes
- Copy of your DD-214 showing dates of service and character of service (type of discharge)

ATTESTATION OF TERMINAL ILLNESS

I _____ hereby certify that I receive medical services from a VA facility and have been diagnosed with a terminal illness of _____ (insert name of disease or illness) with a life expectancy of six (6) months or less. Under penalties including, but not limited to, perjury, and administrative action, I declare that I have examined the application, all supporting documents submitted by me in connection therewith, and all statements contained therein, and to the best of my knowledge, they are true, correct, and complete.

Signature (no stamps accepted) – Sign in blue ink only

Date of signature (mm/dd/yyyy)

State of Illinois

County of _____.

Signed (or subscribed or attested) before me on _____ (date)

by _____ (name of person).

(seal)

Signature of Notary Public