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 |
|---|---|---|
| | Have you ever applied for a Medical Marijuana Id card? | ☐ Yes ☐ No |

Print clearly. Incomplete applications may be denied. Denied applicants are required to wait six months before beginning the application process again. Application fees are non-refundable. ***Faxed and electronic copies of applications will not be accepted***.

## PATIENT CONTACT INFORMATION

| **Name:** *(LAST, FIRST, M.I.)* ☐ M ☐ F | **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.

* ***To ensure confidentiality, information regarding application status will not be given over the phone***. Once applications are processed, communication will be sent to the Patient's residence with further instructions for the finalization of the Registry Card.
* Applicants/patients are required by law to notify DPH Office of Medical Marijuana with any changes in information within 10 days of the change. Failure to do so can result in fines.
* Any registry card that is lost or stolen must be reported to DPH Office of Medical Marijuana immediately.
* Patient information changes that are printed on the Registry Card (such as name or address) will require a new card issued.

| | |
|---|---|
| _____ *initial* | I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge. |
| _____ *initial* | I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided. |
| _____ *initial* | I attest that I 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. |

| _____ Patient Signature | _____ Date of Signature |
|---|---|

## 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: _____

## PHYSICIAN CERTIFICATION

**PATIENT'S INSTRUCTIONS:** Have your physician 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 physician's signature date.**
Faxed and electronic copies will not be accepted.

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

**PHYSICIAN'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** | ☐ | **CBD RICH ONLY PATIENT CARD** | ☐ |

### PHYSICIAN 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:** *(Must be DO or MD)* |
| **Address:** *(City, State, ZIP Code)* | | |
| **Phone:** | **Fax:** | **Email:** *(not required)* |
| **Medical Specialty:** *(Oncology, Neurology, etc)* | | |

### DEBILITATING MEDICAL CONDITION

**Listed below are the ONLY qualifying debilitating medical conditions as stated in Title 16 of the Delaware Code, 4902A (3)**

☐ Cancer
☐ Anxiety (CBD RICH ONLY PATIENT CARD)
☐ Terminal Illness
☐ Positive status for Human Immunodeficiency Virus (HIV Positive)
☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Decompensated Cirrhosis
☐ Amyotrophic Lateral Sclerosis (ALS / Lou Gehrig's Disease)
☐ Glaucoma
☐ Chronic debilitating Migraines or New daily persistent headache
☐ Agitation of Alzheimer's Disease
☐ Post-traumatic Stress Disorder (PTSD)
☐ Autism with aggressive behavior
☐ A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following ***(Specify in comments)***:
- ☐ Cachexia or Wasting Syndrome
- ☐ Severe, debilitating pain that has not responded to previously prescribed medication or surgical measure for more than three (3) months, or for which other treatment options produced serious side effects.
- ☐ Intractable Nausea
- ☐ Seizures
- ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of Multiple Sclerosis

## PHYSICIAN CERTIFICATION (CONTINUED)

### PHYSICIAN CERTIFICATION

I have established a bona fide physician-patient relationship with _____, (patient) beginning _____ (date of first patient visit to your office).
This qualifying patient is under my care, either for primary care or the debilitating medical condition listed on this form

_____ *Physician Initials*

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

_____ *Physician Initials*

I have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians for the qualifying condition. I have established a medical record of the qualifying 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.

_____ *Physician Initials*

I have assessed this patient for history of substance use disorder.

_____ *Physician Initials*

If a history of substance abuse has been identified. The Department of Health and Social Services (DHSS) requests your acknowledgement of the history of substance abuse, and you confirmation that medical marijuana is an appropriate treatment option to include a commitment to monitor patient closely. (Please initial here if indicated).

_____ *Physician Initials*

**Physician's Attestation**

I _____, (physician), hereby certify that I am a physician 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 qualifying debilitating medical condition or symptoms associated with the debilitating 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 attest that the information provide in this written certification is true and correct.

_____ Physician'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 physician(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:

_____, (physician'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 one (1) year 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 initial all three of the Patient Attestation Statements and sign on the signature line? (Page 1)** |
| ☐ | **Did you include the Physician Certification forms completed and signed by your physician? (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 $50.00 non-refundable application fee or your signed Low Income Charge Request form with supporting documentation? Please make check or money order payable to State of Delaware, MMP** |