Cannabis Control Commission
COMMONWEALTH OF MASSACHUSETTS

Medical Use of Marijuana Program: Patient Registration Form

Renewing your registration ***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 renewal form is for use by patients who do not have access to the internet or are unable to register online.

You are strongly encouraged to renew your registration online. Please visit our online guide to Patients and Caregivers at https://masscannabiscontrol.com/patients-caregivers/.

Registrations expire annually. You may re-apply for registration, up to 60 days before the date that your registration expires. It is highly recommended that applicants apply for a registration renewal prior to the expiration of their current Program ID Card. This will ensure that there is no gap in the applicant's active status.

Please note, to maintain an active registration as a patient with the Program, you must also have an active certification from your certifying health care provider. Please ensure you have an active certification prior to renewal. You may call the Program at 833-869-6820 to check the status of your certification.

When completing this application, please fill in all fields and mail in the registration renewal form along with the required documents listed below.

Preparing for Registration

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; or
- A Permanent Resident Card and another document that proves your Massachusetts residency.

If submitting a passport, U.S. military ID, or Permanent Resident Card:

If you submit a passport, U.S. military ID, or Permanent Resident Card as your valid form of ID, you must also submit a document that proves you are a resident of Massachusetts (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.

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)

To:

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

Personal Caregiver Information

If you did not elect to have a personal caregiver last year to assist you with your medical use of marijuana, but wish to do so this year, please follow the below instructions.

If you do not have, or want, a personal caregiver, please skip to the next section.

You may designate up to two personal caregivers who are not currently designated by another patient, unless that personal caregiver is your immediate family member.

Please note that you may also select a personal caregiver at any time after renewing your registration by contacting the Program at 833-869-6820 to request a Personal Caregiver Registration Form.

Please follow these steps:

- **STEP 1:** If you wish to renew your personal caregiver's registration, please skip to Step 2. If you are selecting a new personal caregiver, please complete Section B of the Patient Registration Renewal Form.
- **STEP 2:** After you submit your registration renewal form, the Program will mail you an application with a PIN to give to your personal caregiver for them to register or renew as a caregiver.
- **STEP 3:** Provide the PIN to your personal caregiver and direct them to register or renew with the Program. Your personal caregiver must use this PIN in order to register.
- **STEP 4:** After your personal caregiver has submitted an application, 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 or renewal, your personal caregiver may assist you with your medical use of marijuana.

Please note, if you do not validate your caregiver within 60 days, your caregiver will no longer be linked.

Other Important Information About Registration

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 to be authorized 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.

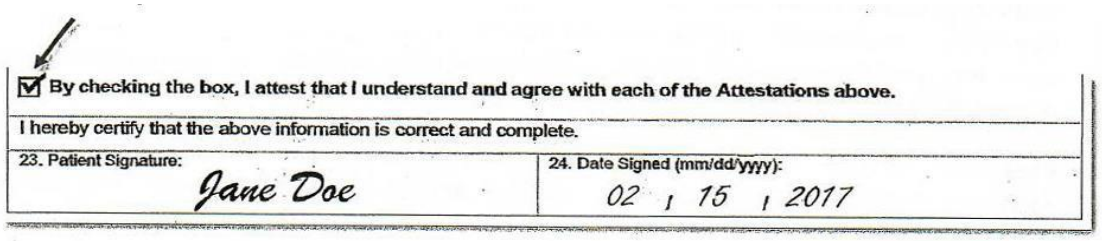
Before Mailing in Your Form

Has your driver's license or your form of identification (ID) expired in the last year?

- Make sure to update your information on the Patient Registration Renewal Form.
- Make a copy of your new driver's license and mail it in with the form.

Did you make sure to checkmark that you understand and agree with the attestations?

- It is located in Section C, page three (3), above Item 23 (Patient Signature) and Item 24



(Date Signed) on the form:

Did you make sure to Sign and Date your form?

- Located in Section C, page three (3), Item 23, and Item 24.

Did you include ALL pages of the Patient Registration Renewal Form?

- There are three (3) pages in total.

Make sure the address on the envelope is correct:

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

Please note: the U.S. Postal Service will not forward mail from the Cannabis Control Commission.

PATIENT REGISTRATION RENEWAL 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. 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 ☐ OTHER____

9. Mother's maiden last name: _____

10. Please check all that apply:

☐ No changes have been made to my name from last year's registration.
☐ No changes have been made to my address from last year's registration.
☐ My valid form of ID has not expired since last year's registration.

You must update the Program and provide a copy of your current and valid form of ID if you did not check all three boxes.

IF THERE ARE NO CHANGES, PLEASE SKIP TO SECTION B.

RESIDENTIAL ADDRESS OF PATIENT (FOR CHANGES ONLY)

Address: _____
11a. Residential address of patient *11b. Apt. or suite number*

_____
*12. City*_____ *13. State* _____ *14. ZIP code*____

MAILING ADDRESS OF PATIENT
(FOR CHANGES ONLY AND IF DIFFERENT FROM RESIDENTIAL ADDRESS)

Address: _____
15a. Mailing address of patient *15b. Apt. or suite number*

_____
*16. City*_____ *17. State*_____ *18. ZIP code*

VALID FORM OF ID

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 ☐ Permanent Res Card ☐

_____ _____ / _____ / _____
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: _____ _____
d. Last *e. First*

f. 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 M. G. L. c. 94I: *Medical use of Marijuana* and 935 CMR 501.000, 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 Medical Use of Marijuana Program (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, 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 me 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 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 Program. If I do not want to receive emails from the Program, I must email the Program at Commission@CCCMass.com. If I decide at any time, I no longer want to receive emails from the Program, I must email the Program at Commission@CCCMass.com. 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 above.**

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

23. Patient signature: _____

24. Date signed (mm/dd/yyyy): ____/____/____