

# Medical Use of Marijuana Program: Personal Caregiver Registration Form

**Personal caregiver registrations expire annually. You may re-apply for personal caregiver registration, on an annual basis, up to 60 days before the date that your registration expires.**

Registering online with the Medical Use of Marijuana Program (Program) is the fastest and most convenient way to complete the personal caregiver registration process in order to assist a registered qualifying patient with the medical use of marijuana. This paper registration form is for use by personal caregivers who do not have access to the internet and are unable to register online.

**In order to register as a personal caregiver, you must obtain a PIN** from the patient you will be assisting with the medical use of marijuana. You will enter this PIN in the registration form.

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

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

- The **PIN** provided to you by the registered qualifying patient;
- A **copy** of a valid form of identification (ID); and
- A photograph of yourself (as explained below).

## Valid Form of ID

*Valid forms of ID include one of the following:*

- State-issued driver's license;
- ID card issued by your state's Registry of Motor Vehicles;



- U.S. passport and another document that proves your primary residence; or
- U.S. military ID and another document that proves your primary residence.

**If submitting a driver's license or ID card issued by your state's Registry of Motor Vehicles:**

If you submit a driver's license or ID card issued by your state's Registry of Motor Vehicles as your valid form of ID, the name and address on your registration form must match the name and address on your driver's license or ID card issued by your state's Registry of Motor Vehicles.

**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.

## Registration Process

Now that you have received the PIN and gathered the necessary documents, you may fill out the attached registration form.

Complete all required sections of the form neatly and accurately. **Incomplete forms that are not signed and dated, or are not readable, will not be processed and will be returned to the applicant.**

In order to register as a personal caregiver, please follow these steps:

**STEP 1:** Fill out the attached Personal Caregiver Registration Form.

**STEP 2:** Mail your:

- Completed registration form;
- Copy of a valid form of ID (and a copy of proof of primary residence, if applicable); and
- Photograph

To:

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

**STEP 3:** Notify the patient that you have submitted a personal caregiver registration form and that as a patient they must verify with the Program that you are their personal caregiver.



**STEP 4:** After the patient has verified you as their personal caregiver, the Program will process your registration form. You will then 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. Registrations are processed in the order they are received.

Following completion of the registration process, you will receive your Program ID Card in the mail.

### **Other Important Information About Registration**

You and your patient must maintain an active registration with the Program, and your patient must maintain an active certification from their clinician/health care provider, in order for you, as a personal caregiver, 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.

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.

### **Valid Form of ID**

After registering with the Program, your valid form of ID on file with the Program must remain active and not expired in order to access a Medical Marijuana Treatment Center (MTC) or obtain marijuana for medical use from an MTC on behalf of a patient.

### **Change of Registration Information**

If there is any change to the information you submitted for registration (such as a change in your name, email, address, or phone number), you must notify the Program within five (5) business days after the date of this change by calling 833-869-6820.

### **Accessing an MTC**



In order to access an MTC, or obtain marijuana for medical use from an MTC, a personal caregiver must:

- Present their Program ID Card and their valid form of ID that they used to register with the Program;
- Have an active registration with the Program;
- Maintain on file with the Program a form of ID that is active and not expired; and
- Be linked to a patient with an active registration with the Program and an active certification from their clinician/health care provider.

### Questions

Should you have questions regarding the registration process, please contact the Program at 833-869-6820.



**PERSONAL CAREGIVER REGISTRATION FORM** (Please Print)**SECTION A: PERSONAL CAREGIVER INFORMATION (REQUIRED)**

*The name and address on this form must match the name and address on your valid form of ID, or your proof of primary residence.*

1. PIN (as provided to you by your patient): \_\_\_\_\_

Full name: \_\_\_\_\_

2. Last 3. First M.I.

4. Last 4 digits of Social Security Number: \_\_\_\_\_

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

6. Phone number: (            ) \_\_\_\_\_

7. Email address: \_\_\_\_\_

8. Gender:            MALE            FEMALE  
                         ☐            ☐

9. I (the caregiver) 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 caregiver	11b. Apt. or suite number
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MA	
12. City	13. State      14. ZIP code

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

Address:

<i>15a. Address</i>	<i>15b. Apt. or suite number</i>
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		MA
16. City		17. State      18. ZIP code

### 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: QUALIFYING PATIENT INFORMATION (REQUIRED)

Please indicate the name of the qualifying patient you will be assisting with the medical use of marijuana and your relationship to the patient.

Patient  
name:

22. Last

23. First

M.I.

24. Personal caregiver  
relation to patient:

Immediate family member

☐

Other

☐

### SECTION C: PERSONAL CAREGIVER 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 will not engage in the diversion of marijuana purchased for medical use.
- I attest that I will only assist the patient whom has designated me to be their caregiver in the medical use of marijuana that is consistent with their certifying physician's recommendations.
- 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 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 Program, if my Program ID Card has been lost, stolen, or destroyed, or if my patient has deceased.
- I understand that I must carry my Program ID at all times while in possession of marijuana for medical use.
- 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 database for record keeping 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 will not serve as a personal caregiver for more than one registered qualifying patient at one time.



- Exceptions: Employee(s) of a hospice provider, nursing facility, medical facility providing care to a qualifying patient admitted to or residing at that facility, visiting nurse, home health aide, personal care attendant, or an immediate family member (spouse, parent, child, grandparent, grandchild, sibling, including in-laws) of more than one registered qualifying patient.
- I will not receive payment or other compensation for services that I provide as a personal caregiver, but I may be reimbursed for reasonable expenses that I have incurred in providing my services if my patient agrees to reimburse my expenses. I understand that my time is not considered a reasonable expense.
- I will not:
  - Consume, by any means, marijuana that has been dispensed to or cultivated for my patient;
  - Sell, provide, or otherwise divert marijuana that has been dispensed to or cultivated for my patient;
  - Cultivate marijuana for my own use;
  - Cultivate marijuana for my patient unless my patient has been approved for a Hardship Cultivation Registration by the Cannabis Control Commission;
  - Cultivate marijuana for purposes of selling or providing marijuana to anyone other than my patient; or
  - Allow my patient, if my patient is under 18 years of age, to possess marijuana at any time when he or she is not in my presence.
- 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 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 [MedicalMarijuana@state.ma.us](mailto: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](mailto: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 above.**

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

23. Personal  
caregiver  
signature: \_\_\_\_\_

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