State of Illinois
Illinois Department of Public Health

CG

Illinois Medical Cannabis Patient Program

Application for a Designated Caregiver Registry Identification Card

*****Do not use this form for Terminal Illness*****

APPLICATION TYPE (Check the appropriate answer)

- ❑ **New:** I have never had an Illinois Medical Cannabis Designated Caregiver Registry Identification Card.
- ❑ **New with Current Patient:** I have never had an Illinois Medical Cannabis Designated Caregiver Registry Identification Card, but I am applying to be a caregiver for a patient who has already been approved.

CAREGIVER INFORMATION

Social Security Number (###-##-####)	Driver's License Number	Driver's License State	No Driver's License ❑
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 ❑ Male ❑ Female		

QUALIFYING PATIENT INFORMATION

First Name	Middle Name	Last Name	
Home Address			
Apartment or Suite #	City	State IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address		
Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female		

SIGNATURE of Qualifying Patient _____ DATE (mm/dd/yyyy) _____

This application was prepared by:

PRINT/TYPE PREPARER'S NAME _____ DATE (mm/dd/yyyy) _____

FIRM OR ORGANIZATION NAME _____ PHONE NUMBER _____

Printed by Authority of the State of Illinois

IOCI 20-446

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ATTESTATIONS

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 Designated Caregiver Registry Identification Card and other administrative, civil or criminal penalties.

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) 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;

(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 DATE (mm/dd/yyyy)

APPLICATION FEES

Provide a check or money order payable to Illinois Department of Public Health.

Choose One:

Application Fee for Designated Caregiver

❑ $25 – One-Year Registry Card

❑ $50 – Two-Year Registry Card

❑ $75 – Three-Year Registry Card

❑ $75 – Caregiver applying separately for a patient who has already been registered (the expiration date for the caregiver and the patient card will be the same)

APPLICATION FEES ARE NOT REFUNDABLE

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REQUIRED DOCUMENTS

	Place the following items in an envelope or upload in the electronic application:
❑	**Non-refundable application fee (Check or Money Order to Illinois Department of Public Health)**
❑	**Photograph** • Taken in the last 30 days • 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.
❑	**Proof of age and identity** Submit a clear, color copy of an Illinois Driver's License, Illinois State ID, or the photograph page of a US passport.
❑	**Proof of residency** If your Driver's License, Temporary Visitor Driver's License or State ID address matches your application submit **one** additional proof of residency. If you submit a US Passport as your proof of identity or your Driver's License or State ID address does not match the address on your application, submit two of the following: • Pay stub or electronic deposit receipt, issued less than 60 days prior to the application date, that shows evidence of withholding for State income tax • Valid voter registration card with an address in Illinois • Bank statement (dated less than 90 days prior to application) or credit card statement (dated less than 60 days prior to application); • Deed/title, mortgage or rental/lease agreement; property tax bill; • Insurance policy (current coverage for automobile, homeowner's, health or medical, or renter's); • Medical claim or statement of benefits (from a hospital or health clinic, private insurance company or public (government) agency, dated less than 12 months prior to application) • Tuition invoice/official mail from college or university, dated less than the 12 months prior to application • Utility bill, including, but not limited to, those for electric, water, refuse, telephone land-line, cellular phone, cable or gas, issued less than 60 days prior to application • W-2 from the most recent tax year Proof of residency must include name and address and match the address on the application

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.

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