State of Illinois
Illinois Department of Public Health

Illinois Medical Cannabis Patient Program

Application for Registry Identification Card for Qualifying Patients Under 18 Years of Age and their Designated Caregiver

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

MINOR (under 18 years of age) QUALIFYING PATIENT 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		

RECOMMENDING HEALTH CARE PROFESSIONAL INFORMATION

First Name	Middle Name	Last Name	
Office Address			
Suite Number	City	State IL	ZIP Code

REVIEWING HEALTH CARE PROFESSIONAL INFORMATION

First Name	Middle Name	Last Name	
Office Address			
Suite Number	City	State IL	ZIP Code

SIGNATURE OF MINOR, IF AGE 16 OR OLDER _______________ DATE (mm/dd/yyyy) _______________

This application was prepared by:

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

FIRM OR ORGANIZATION NAME _______________ PHONE NUMBER _______________

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12/19

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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.

DESIGNATED CAREGIVER INFORMATION

The custodial parent or legal guardian shall serve as the designated caregiver and must complete the following information. A second caregiver may be identified by completing a caregiver application and payment of a caregiver registration fee.

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		

SIGNATURE OF DESIGNATED CAREGIVER

DATE (mm/dd/yyyy)

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CERTIFICATIONS (To be completed by the designated caregiver)

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 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.

DESIGNATED CAREGIVER SIGNATURE ____________________ DATE (mm/dd/yyyy) ____________

APPLICATION FEES

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

Choose One:

Application Fee

❑ $100 – One-Year Registry Card

❑ $200 – Two-Year Registry Card

❑ $250 – Three-Year Registry Card

APPLICATION FEES ARE NOT REFUNDABLE

One caregiver is included in the application for a minor qualifying patient at no charge. A second caregiver may be added by completing a separate caregiver application and submitting the supporting documents and appropriate fee.

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REQUIRED DOCUMENTS

Place the following items in an envelope or upload with an electronic application:	
❑	**Non-refundable application fee (Check or Money Order to Illinois Department of Public Health)**
❑	**Photograph of Designated Caregiver** • 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 Designated Caregiver's Residency, Age, and Identity** Submit a clear, color copy of an Illinois Driver's License or Illinois State ID. If the address on your driver's license or ID does not match the address on your application, please submit one additional proof of residency.
❑	**Copy of Minor Qualifying Patient's Birth Certificate**
❑	**Health Care Professional Written Certification** and **Reviewing Health Care Professional Written Certification**

Minor qualifying patients do not need to submit a photo.

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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