Medical Marijuana Program
APPLICATION/RENEWAL
(Please Print)

For application instructions, view page 4.

This application is for:

☐ Patient Only (Applicant) ☐ Primary Caregiver Only ☐ Patient and Primary Caregiver

SECTION 1 TO BE COMPLETED BY ALL APPLICANTS.

Name (last, first, middle initial)

Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

Additional contact information

Is applicant under 18 years of age? ☐ Yes ☐ No

If yes, complete Section 2 for the parent, legal guardian, or person with legal authority to make medical decisions for minor applicant, unless minor applicant is *(check one)*:

☐ Lawfully emancipated; *or* ☐ Declares self-sufficient minor status or is a minor capable of medical consent

SECTION 2 TO BE COMPLETED FOR MINOR APPLICANT IDENTIFIED IN SECTION 1.

Parent/guardian/other name (last, first, middle initial)		Telephone Number if Different From Above ( )	
Mailing address if different from above (number, street)	City	State	ZIP code

Relation to applicant *(check one)*:

☐ Parent with legal authority to make medical decisions
☐ Legal Guardian
☐ Other person or entity with legal authority to make medical decisions

SECTION 3 TO BE COMPLETED IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Does the applicant have the capacity to make medical decisions? ☐ Yes ☐ No
If "No," enter the name and address of person acting on the applicant's behalf:

Name (last, first, middle initial.)		Telephone number ( )	
Mailing address (number, street)	City	State	ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: ____________________

SECTION 4 TO BE COMPLETED BY THE PRIMARY CAREGIVER REQUESTING AN IDENTIFICATION CARD.

Name (last, first, middle initial)			Date of Birth (if less than 18 years of age)
Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

Primary Caregiver Duties: *(Document how you consistently assume responsibility for the housing, health, or safety of the applicant.)*

Check your designation as a primary caregiver from the following list:

☐ I am the parent of the applicant or the person entitled to make medical decisions on behalf of the applicant.
☐ I am the designated primary caregiver for only this applicant.
☐ I am the designated primary caregiver for another applicant (qualified patient) in this county.
☐ I am the designated primary caregiver for an applicant (qualified patient) in a different county.

County name: ______________________

Check one of the two following choices if your status as a primary caregiver is linked to a health related entity:

☐ I am the owner/operator of a clinic pursuant to Chapter 1 (commencing with Section 1200), Division 2 of the Health and Safety (H&S) Code.
☐ I am a clinic/facility/hospice or home health agency employee* designated by the owner/operator to serve as a primary caregiver.

Check all that apply:

☐ This health care facility is licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.01 (commencing with Section 1568.01), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.2 (commencing with Section 1569), Division 2 of the H&S Code.
☐ This hospice or home health agency is licensed pursuant to Chapter 8 (commencing with Section 1725), Division 2 of the H&S Code.

* Health and Safety Code Section 11362.7(d)(1) limits a maximum of three employees that may serve as primary caregivers. **Note:** Include a copy of this page for each caregiver.

Primary Caregiver Declaration: I understand and acknowledge my assigned duties as the designated primary caregiver for

______________________ . I understand that if the applicant's identification card expires, then my primary caregiver
Applicant's name

identification card shall also expire. I agree to return my primary caregiver identification card to this county health department or its designee if this applicant changes primary caregivers. I agree that if I am the owner or operator of a health care facility designated as the primary caregiver of this applicant, that I shall notify this county health department or its designee if a change of primary caregivers is made. I declare under penalty of perjury that the information I provided on this form is true and correct.

____
Printed name of primary caregiver

______________________ ______________________
Signature of primary caregiver Date