IOWA DEPARTMENT OF PUBLIC HEALTH

Office of Medical Cannabidiol

For the most current information regarding this application, medical cannabidiol laws in the state of Iowa and more, see the official website: https://idph.iowa.gov/mcarcp

MEDICAL CANNABIDIOL REGISTRATION CARD – PATIENT APPLICATION

Mail completed application and required materials to: **Iowa Department of Public Health** **ATTN: OMC** **321 E. 12th Street** **Des Moines, IA 50319-0075**	☐ New Patient	☐ Renewing Patient
	Have you ever applied for a Medical Cannabidiol Registration Card in Iowa?	☐ Yes ☐ No

Print clearly. Incomplete applications may be denied. Application fees are non-returnable.

PATIENT INFORMATION

Name (First, Middle Initial, Last)			
Sex Designation ☐ Male ☐ Female		**Date of Birth** (Must be 18 or Older)	**Age**
Where You Live	**Permanent Iowa Address** (Street, Apt. #)		
	Address (City, State ZIP Code)		
Where You Get Mail	**Address** (P.O. Box, Apt. #)		
	Address (City, State ZIP Code)		
Primary Phone Number		☐ Check this box if a confidential message may be left at this number.	
Secondary Phone Number		☐ Check this box if a confidential message may be left at this number.	

PATIENT ATTESTATION STATEMENT

PATIENT INSTRUCTION: Complete and sign the following release statement. This statement will allow the Office of Medical Cannabidiol staff to verify information with the certifying physician(s) relating to your qualifying debilitating medical condition, and the dispensing of cannabidiol related to that condition. It will also allow the Office to complete the processing of your application and issuance of your Medical Cannabidiol Registration Card.

I, _____, (patient), hereby authorize the Iowa Department of Public Health (IDPH), Office of Medical Cannabidiol, to exchange information about my qualifying debilitating medical condition with my certifying health care practitioner, the Iowa-licensed medical cannabidiol dispensaries, and the Department of Transportation in relation to the issuance of a Medical Cannabidiol Registration Card, and the dispensing of any cannabidiol/cannabinoid product.

By signing below, I certify that the information on this application is complete, true and submitted for the purpose of obtaining a State of Iowa Medical Cannabidiol Registration Card. If approved for the Registration Card, I agree to the terms of the Iowa Medical Cannabidiol Act, Chapter 124E. A copy of the act may be found at this web address: https://idph.iowa.gov/mcarcp

- ***To ensure confidentiality, information regarding application status will not be given over the phone.*** Once applications are processed, communication will be sent to the Patient's residence with further instructions for the finalization of the Registration Card.
- You are required by law to notify the Iowa Department of Public Health Office of Medical Cannabidiol with any changes in information within 10 days of the change.
- Any Registration Card that is lost or stolen must be reported to the Office of Medical Cannabidiol immediately.
- Patient information changes that are printed on the Registration Card (such as name or address) will require a new card to be issued.

_____ Initials	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
_____ Initials	I agree to notify the Office of Medical Cannabidiol, in writing, within 10 days of any change to the information provided.
_____ Initials	I have not been convicted of a disqualifying felony offense which is a violation under federal or state law of a felony under federal or state law, which has as an element the possession, use or distribution of a controlled substance, as defined in 21 U.S. C. §802 (6).

I certify under penalty of perjury that all of the information provided by me on this application is true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Medical Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand that I am required to know and comply with the provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Medical Cannabidiol Registration Card.**

Patient Signature	**Date of Signature**

If patient is unable to provide own signature, a legal guardian or power of attorney may provide the signature.

Legal Guardian or Power of Attorney Signature	**Date of Signature**

---------- Next Section ----------

PRIMARY CAREGIVER DESIGNATION - OPTIONAL

Primary Caregiver means a person, who is a resident of Iowa or a bordering state, including but not limited to a parent or legal guardian, at least eighteen years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol.

Patient Name
(First, Middle Initial, Last)

I, _____, (patient), hereby authorize the following person(s) to be my designated primary caregiver for the purpose of managing my well-being related to the use of medical cannabidiol. I authorize this/these caregiver(s) to assist me in the transportation, storage and use of medical cannabidiol. This/these person(s) will be responsible for applying through a separate application form for their own Medical Cannabidiol Registration Cards as my caregiver(s).

Designated Caregiver 1	**Caregiver Name** (First, Middle Initial, Last)
	Date of Birth (Must be 18 or Older)
	Caregiver Permanent Address (Street, Apt. #)
	Caregiver Address (City, State ZIP Code)
	Caregiver Mailing Address (P.O. Box, Apt. #)
	Caregiver Address (City, State ZIP Code)
	Caregiver Telephone Number

Designated Caregiver 2 - Optional	
	Caregiver Name (First, Middle Initial, Last)
	Date of Birth (Must be 18 or Older)
	Caregiver Permanent Address (Street, Apt. #)
	Caregiver Address (City, State ZIP Code)
	Caregiver Mailing Address (P.O. Box, Apt. #)
	Caregiver Address (City, State ZIP Code)
	Caregiver Telephone Number

Designated Caregiver 3 - Optional	
	Caregiver Name (First, Middle Initial, Last)
	Date of Birth (Must be 18 or Older)
	Caregiver Permanent Address (Street, Apt. #)
	Caregiver Address (City, State ZIP Code)
	Caregiver Mailing Address (P.O. Box, Apt. #)
	Caregiver Address (City, State ZIP Code)
	Caregiver Telephone Number

Patient Signature	**Date of Signature**

If patient is unable to provide own signature, a legal guardian or power of attorney may provide the signature.

Legal Guardian or Power of Attorney Signature	**Date of Signature**

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HEALTH CARE PRACTITIONER CERTIFICATION

PATIENT INSTRUCTIONS: Have your physician complete this entire section. This section should be submitted as a part of your completed application to the Office of Medical Cannabidiol. Partial applications will not be accepted. The patient application must be received by the Office of Medical Cannabidiol within **60 days** of the physician's signature date. Faxed and electronic copies will not be accepted.

NOTE: THIS DOES NOT CONSTITUTE A PRESCRIPTION FOR CANNIBIDIOL or MEDICAL MARIJUANA.

HEALTH CARE PRACTITIONER INSTRUCTIONS: Print clearly. Answer all of the questions with information in the patient's medical record.

Patient Name
(First, Middle Initial, Last)

HEALTH CARE PRACTITIONER INFORMATION

Health Care Practitioner means an individual licensed under Chapter 148 to practice medicine and surgery or osteopathic medicine and surgery who is a patient's primary care provider. "Health Care Practitioner" shall not include a physician assistant licensed under Chapter 148C or an advanced registered nurse practitioner licensed pursuant to Chapter 152 or 152E.

Physician Name
(First, Middle Initial, Last, Suffix)

Medical License Number	**License State** (Must be licensed in Iowa)	**License Type** (Must be DO or MD)

Practice Address
(Street)

Practice Address
(P.O. Box, Suite #)

Address
(City, State ZIP Code)

Phone Number	**Fax Number**

Medical Specialty (Oncology, Neurology, Pain Management, etc.)

PATIENT'S QUALIFYING DEBILITATING MEDICAL CONDITION

INSTRUCTIONS: Please mark the debilitating medical conditions which qualify the patient for a Medical Cannabidiol Registration Card.

☐	Cancer with severe or chronic pain
☐	Cancer with nausea or severe vomiting
☐	Cancer with cachexia or severe wasting
☐	Multiple sclerosis with severe and persistent muscle spasms
☐	Seizures, including those characteristic of epilepsy
☐	AIDS or HIV as defined in Iowa Code, section 141A.1
☐	Crohn's disease
☐	Amyotrophic lateral sclerosis
☐	Any terminal illness with a probable life expectancy of under one year and severe or chronic pain
☐	Any terminal illness with a probable life expectancy of under one year and nausea or severe vomiting
☐	Any terminal illness with a probable life expectancy of under one year and cachexia or severe wasting
☐	Parkinson's disease
☐	Untreatable Pain (*means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.*)

Patient Name (First, Middle Initial, Last)	
HEALTH CARE PRACTITIONER CERTIFICATION	
INSTRUCTIONS: Please initial all sections. All must be initialed in order for the application to be approved.	
I have established a patient-provider relationship with the patient identified above.	_____ Initials
I am a primary care provider involved in the diagnosis and treatment of this patient's debilitating medical condition.	_____ Initials
I have determined in my medical judgment that this patient whom I have examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol under Iowa Code, chapter 124E.	_____ Initials
I have provided this patient with the explanatory information provided by the Iowa Department of Public Health (found on the Department's website at this web address: https://idph.iowa.gov/Medical-Cannabidiol-Act-Registration-Card-Program/Medical-Cannabidiol-Education-Material) on the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.	_____ Initials
I agree to determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.	_____ Initials
I agree to otherwise comply with all requirements established by the Iowa Department of Public Health pursuant to rule, and provide other information as requested.	_____ Initials
I understand that I may provide, but have no duty to provide, this written certification of debilitating medical condition for the applicant patient.	_____ Initials

HEALTH CARE PRACTITIONER ATTESTATION

I designate the person(s) named in the Primary Caregiver Section as Primary Caregiver(s) in relation to the patient to manage the patient's well-being with respect to the use of medical cannabidiol pursuant to the provisions of Iowa Code chapter 124.E.

I certify under penalty of perjury that the foregoing statements and all information provided by me on this application are true and correct. I understand the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand this application does not, by itself, provide authorization for the Medical Cannabidiol Registration Card for the above named patient/and/or caregiver(s).**

Health Care Practitioner Signature	**Date of Signature**

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PATIENT APPLICATION CHECKLIST

Patient Name
(First, Middle Initial, Last)

PATIENT INFORMATION AND ATTESTATION SECTION

☐	I have signed, dated and initialed all areas of this application in the PATIENT ATTESTATION SECTION.
☐	If the patient does not have the capacity to sign, date and initial this form, the legal guardian or power of attorney for the patient listed on this application, has signed, dated and initialed all areas of this application in the PATIENT ATTESTATION SECTION.

PRIMARY CAREGIVER DESIGNATION SECTION

☐	If the patient needs to have a caretaker with responsibility for managing his or her well-being in relation to the use of medical cannabidiol, or to assist with the transportation and handling of the medical cannabidiol, information for the selected caregivers is provided in the PRIMARY CAREGIVER SECTION.

HEALTH CARE PRACTITIONER and MEDICAL CONDITION CERTIFICATION SECTION

☐	My health care practitioner has completed the HEALTH CARE PRACTITIONER SECTION and certified that I have one or more of the qualifying debilitating medical conditions.

APPLICANT – PATIENT - DOCUMENTATION

☐	A clear copy of the patient's valid photo identification card is attached.
☐	A valid Iowa driver's license
☐	A valid Iowa non-operator's identification card

☐ A clear <u>copy of one of the following items</u> showing the patient's name and permanent Iowa address is attached.

☐	A valid Iowa driver's license	☐	A utility bill
☐	A valid Iowa non-operator's identification card	☐	A valid Iowa voter registration card
☐	A current Iowa vehicle registration certificate	☐	A statement from a financial institution
☐	A residential lease agreement	☐	A check or pay stub from an employer

☐	Valid documentation establishing a filing of homestead or military tax exemption on property located in Iowa
☐	Another valid item with documentation showing established residency as approved by the Iowa Department of Public Health (Call 515-281-5616 to discuss other valid items.)

APPLICATION FEE

☐	**Regular Application Fee - $100**
☐	**Reduced Application Fee - $25** (For a patient who qualifies in one of the categories shown below.) Please mark which category applies to the patient.

☐	**Social Security Disability Benefit Recipient** (Provide documentation, if applicable)
☐	**Supplemental Security Income Payment Recipient** (Provide documentation, if applicable)
☐	**Iowa Medicaid** (Provide documentation, if applicable)
☐	**Hawk-I** (Provide documentation, if applicable)

Fee Included: ☐ **$100** ☐ **$25** (A check should be made out to "Iowa Department of Public Health." Cash will also be accepted.)