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)			Date of birth (if less than 18 years of age)
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

SECTION 5 **ALL APPLICANTS MUST IDENTIFY THEIR ATTENDING PHYSICIAN.**

Attending physician name			California medical license number
Service mailing address (number, street)			Licensed by *(check one)* ☐ California Board of Podiatric Medicine ☐ Medical Board of California Osteopathic ☐ Medical Board of California
City	State	ZIP code	
Office telephone number ( )	Office fax number ( )		

The Civil Code, Section 1798.17, requires that this notice be provided when collecting personal or confidential information from individuals. Providing the individual information and identifying information requested on this form is mandatory. Failure to furnish this information to the administering agency, in order to process your application for a medical marijuana identification card, will result in denial of your application. The information collected will be verified for accuracy to determine eligibility for a medical marijuana identification card. Sections 11362.71 and 11362.715 of the Health and Safety Code authorize the collection and maintenance of the information.

The Compassionate Use Act of 1996 (Act) (Health & Safety Code, Section 11362.5) ensures that patients and their primary caregivers who possess or cultivate marijuana for the personal medical purposes of the patient upon the recommendation of a physician are not subject to California criminal prosecution or sanction. However, the Act does not protect marijuana plants from seizure nor individuals from federal prosecution under the federal Controlled Substances Act. The information that you provide in this application may be released as required by law, judicial order, or subpoena, and could be used in a federal criminal prosecution.

You have the right to access records containing your personal information which are maintained by the county health department, or the county's designee, and the California Department of Public Health.

Responsibilities

It is my responsibility:

- To notify, within seven days, the county health department or the county's designee of any changes in my attending physician or designated primary caregiver.
- To use my identification card only for the purposes intended by the law.
- To ensure that an authorized medical release of information is on file with my medical provider in order to complete my application.

Declaration

I have read the notice required by Civil Code, Section 1798.17 and understand my responsibilities as stated above concerning my participation in the Medical Marijuana Program. I confirm to the best of my knowledge the listed duties and information provided by my primary caregiver. I declare under penalty of perjury that the information I provided on and with this application is true and correct.

Print name of applicant or legal representative

Signature of applicant or legal representative

Date

MEDICAL MARIJUANA PROGRAM APPLICATION/RENEWAL INSTRUCTIONS

Who may apply?

This program is voluntary. You may apply with the program if you reside in a California county and your doctor recommends the use of medical marijuana for one or more serious medical conditions you suffer from as specified in number 3 below. It is your option to designate a primary caregiver and apply for their identification card at the time you submit your application.

INSTRUCTIONS:

You must complete the *Application/Renewal* form (CDPH 9042) and provide the following information in order to receive an identification card. Submit both the CDPH 9042 and the following information to your county health department (or its designee).

1. Provide a valid government-issued photo identification card (such as a driver's license) issued to you.
   If you are under the age of 18 and lack photographic identification, you may substitute a certified copy of your birth certificate in place of the photo identification. If you designate a primary caregiver on your application form, your primary caregiver must present photographic identification at the same time you submit your application. A primary caregiver may use a certified birth certificate if they are under the age of 18 and lack government-issued photo identification.

2. Provide proof of your county residency with one of the following items:
   - A current rent/mortgage receipt or recent utility bill in your name bearing your current address within the county; or
   - A current California motor vehicle registration in your name bearing your current address within the county

3. Written documentation from your doctor recommending that the use of medical marijuana is appropriate for one or more of the following serious medical conditions you suffer from: Acquired Immune Deficiency Syndrome (AIDS); anorexia; arthritis; cachexia; cancer; chronic pain; glaucoma; migraine; persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis; seizures, including, but not limited to, seizures associated with epilepsy; severe nausea; or any other chronic or persistent medical symptom that either substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 or, if not alleviated, such chronic or persistent medical symptoms may cause serious harm to your safety, or your physical or mental health.

4. Your doctor may use the *Written Documentation of Patient's Medical Records* form (CDPH 9044) to serve as the medical documentation. This form may be obtained from your county or from the California Department of Public Health web site.

5. The administering agency is required to verify an applicant's medical documentation. It is the applicant's responsibility to ensure that the authorized medical release of information is on file with their medical provider.

6. Contact your local county health department for office locations and identification card fees.

7. Medi-Cal participation at the time of application entitles the applicant to a 50 percent reduction in fees.

8. County Medical Services Program participation at the time of application entitles the applicant's fees to be waived.

9. If you submit an incomplete application and/or fail to provide all the previously mentioned information, your application will be denied and you may be restricted from reapplying for six months.

10. **Application fees are nonrefundable.**

Medical Marijuana Program
WRITTEN DOCUMENTATION OF PATIENT'S MEDICAL RECORDS
(Please Print)

Note to Attending Physician: This is not a mandatory form. If used, this form will serve as written documentation from the attending physician, stating that the patient has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate. A copy of this form must be filed in the attending physician's medical records for the patient. If the patient chooses to apply for a Medical Marijuana Identification card through the county health department or its designee, the agency will call the attending physician to verify the information contained on this form, in accordance with Health & Safety Code, Section11362.72 (a)(3).

Attending physician name			California medical license number
Service mailing address (number, street)			Office telephone number ( )
City	State	ZIP code	Office fax number ( )

Licensed by *(check one)*:

☐ Medical Board of California ☐ Osteopathic Medical Board of California

_____ is a patient under the medical care and supervision of the above
Patient's name

named physician who has diagnosed the patient with one or more of the following medical conditions:

1. Acquired Immune Deficiency Syndrome (AIDS)
2. Anorexia
3. Arthritis
4. Cachexia
5. Cancer
6. Chronic pain
7. Glaucoma
8. Migraine
9. Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis
10. Seizures, including, but not limited to, seizures associated with epilepsy
11. Severe nausea
12. Any other chronic or persistent medical symptom that either:
    a. Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990.
    b. If not alleviated, may cause serious harm to the patient's safety or physical or mental health

ATTENDING PHYSICIAN STATEMENT:

This patient has been diagnosed with one or more of the foregoing medical conditions and the use of medical marijuana is appropriate.

Attending physician's signature	Telephone number	Date

Original—Patient Copy—Patient's File

Riverside University HEALTH SYSTEM Public Health

Medical Marijuana Identification Card (MMIC)

4065 County Circle Drive Suite 103
Riverside CA 92503
Phone#: (951) 358-7932/ (888) 358-7932 ~ Fax#: (951) 358-7934

Date:_____ **No. of pages including cover:** _____

To: _____ **Fax Number:** _____

The identified client submitted an application for the Medical Marijuana Identification Card, which included a letter of recommendation for the purpose of medicinal cannabis.

Please confirm the recommendation by signing and dating this form in the space provided. A signed consent form from the client is attached.

Client's Name	***Client's Date of Birth***	***Validation of Doctor's Recommendation***
Last:_____ ***First:***_____ ***Middle Name:*** _____	___/___/___	( )Yes ( )No Date: _____

The person confirming the recommendation must the **Physician**. Please print and sign **full name**. Please specify if the recommendation is valid by **placing a checkmark** in the box above.

Print Name:_____ Signature: _____

Fax to the MMIC program at **951-358-7934**. In order to process the application, this confirmation must be received no later than **three (3) business days**.

Thank you for your prompt response.

Please contact 1-888-358-7932 if there is an error in transmission.

COUNTY OF RIVERSIDE
DEPARTMENT OF PUBLIC HEALTH
MEDICAL MARIJUANA IDENTIFICATION CARD PROGRAM

GENERAL CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Last Name	First Name	Middle Name	Birthdate
Street	City	Zip Code	Telephone #

I, the undersigned, hereby authorize: (Provider/Organization with the records)

Name		
Street Address		
City	State	Zip Code

To provide to:

County of Riverside Medical Marijuana Identification Card Program
4065 County Circle Drive, Riverside, CA 92503
951-358-7932 * Riverside toll free # 1-888-358-7932 * 951-358-7934 (Fax#)

Access to my medical records for the purpose of:

VERIFICATION OF THE MEDICAL MARIJUANA RECOMMENDATION

Restrictions:

I understand that this authorization is voluntary. Treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. I understand that the physician or health care provider releasing my medical information and PHI (protected health information) pursuant to this request to the person designated on this form may not be held liable for the mis-use of such information when received by the person designated on this form.

I understand that the person designated on this form to receive my information may not further use or disclose my medical information or PHI (protected health information) unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Unless otherwise revoked in writing, this authorization expires in 3 months. You may revoke this authorization in writing at any time by sending a notice to the Medical Marijuana Identification Program.

_____ _____
SIGNATURE OF PATIENT/PARENT-LEGAL GUARDIAN/ PERSONAL REPRESENTATIVE (PLEASE CIRCLE) DATE

_____ _____
SIGNATURE OF WITNESS DATE

Revised 6/21

RIVERSIDE COUNTY DEPARTMENT OF PUBLIC HEALTH-MMIC
DECLARATION OF CARD ISSUANCE

Per Senate Bill 420, Section 11362. (c), Riverside County Department of Public Health, as the designated agency, to administer the Medical Marijuana Identification Card Program, shall issue an identification card to the applicant and/or primary caregiver within 5 working days of approving the application.

YOUR CARD WILL BE MAILED TO YOU

PLEASE INITIAL WHERE INDICATED

_____ initial	I authorize Riverside County MMIC staff to leave a message either with the person answering the phone or by the answering machine to inform me that my card is being mailed. I can expect to receive it within 7-10 working days.
_____ initial	I request that Riverside County MMIC Program mail my ID card to me via U.S. Mail Certified. I understand that someone at my address must sign for the article or it will be returned to the post office and held for 15 days.
_____ initial	Riverside County MMIC is not responsible if card is lost, damaged, or destroyed during the mailing process. The card can be replaced, by submitting a new application and paying the required fees.
_____ initial	If I do not receive my ID card within 14 days, it is my responsibility to contact the U.S. Postal Service @ (800) 275-8777 and to use my tracking number to find the article. If my card has been lost in the mail, it is my responsibility to notify the MMIC Program so that my lost card can be deactivated.

_____ Print name of applicant

_____ Signature of applicant

_____ Date

_____ Primary phone number to contact

_____ Secondary phone number to contact (optional)

MMIC Acknowledgement Notice

I_____have read and understood the following:
Applicant Name

Upon submitting the Medical Marijuana application or renewal with all necessary documentation needed there is a 30 day processing period.

_____**Initial**

All application fees for renewal or appeal are due at the time the application is submitted.
FEES ARE NON REFUNDABLE.

_____**Initial**

If your Medical Marijuana Identification Card is lost, stolen, or damaged you must re-apply and the fees must be paid at that time, before a replacement can be issued.

_____**Initial**

If you submit an incomplete application and/or fail to provide all the previously requested information, your application will be denied and you may also be restricted from reapplying for six months.

_____**Initial**

It is the applicant's responsibility to ensure that the authorized medical release of information is on file with their medical provider. Failure to comply constitutes an incomplete application which cannot be processed and money is **NON REFUNDABLE.**

_____**Initial**

It is the applicant's responsibility to notify the administering agency within seven days of any changes in his/her attending physician or primary caregiver. If you fail to comply, the card shall be deemed expired. You must re-apply and re-pay all fees in order to obtain a new Medical Marijuana Identification card.

_____**Initial**

_____	_____	_____
Applicant Print Name	Applicant's Signature	Date
_____	_____	_____
Caregiver Print Name	Caregiver's Signature	Date
_____	_____	
Clerk Print Name	Date	