State of Illinois
Illinois Department of Public Health

Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card for Qualifying Patients

INSTRUCTIONS

- Qualifying patients whose last name begins with the letters A though L may apply from September 2, 2014 through October 31, 2014.
- Qualifying patients whose last name begins with the letters M though Z may apply from November 1, 2014 through December 31, 2014.

To qualify for a patient registry identification card, a qualifying patient must:

- be a resident of the state of Illinois at the time of application and remain a resident during participation in the program;
- have a qualifying debilitating medical condition;
- have a signed physician certification for the use of medical cannabis;
- complete the fingerprint-based background check and not have been convicted of an excluded offense (a felony under the Illinois Controlled Substances Act, Cannabis Control Act or Methamphetamine Control and Community Protection Act, or similar provisions in a local ordinance or other jurisdiction), unless the Department waives such a conviction(s); and
- be at least 18 years of age.

A complete application must include all of the following:

- ❑ A signed and completed application form.
- ❑ Proof of residency.
- ❑ Proof of identity of the qualifying patient.
- ❑ Proof of age of the qualifying patient.
- ❑ Photograph of the qualifying patient (Contact the Department's Division of Medical Cannabis if a photograph would be in violation of or contradictory to the qualifying patient or designated caregiver's religious convictions).
- ❑ Physician written certification or appropriate documentation for veterans receiving medical care at a U.S. Department of Veterans Affairs facility; your physician must mail in this form.
- ❑ Designated caregiver information, if applicable.
- ❑ Copy of the fingerprint consent form.
- ❑ Excluded offense waiver, if applicable.
- ❑ Selection of medical cannabis dispensary or zone.
- ❑ Application fee.

If mailing, this application must be submitted to:

Illinois Department of Public Health
Division of Medical Cannabis
535 West Jefferson Street
Springfield, Illinois 62761-0001

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P.O.#3115001 250 8/14
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NEW APPLICATION OR RENEWAL (Check the appropriate answer)

- ❑ **New:** I have never had an Illinois Medical Cannabis Registry Identification Card.
- ❑ **Renewal:** I have had an Illinois Medical Cannabis Registry Identification Card.
  My Registry Identification Card Number is _____.

QUALIFYING PATIENT INFORMATION

Social Security Number (### - ## - ####)	Drivers License # (if applicable):	Driver's License State (if applicable):
First Name	Middle Name	Last Name
Home Address		

Apartment or Suite #	City	State IL	ZIP Code

Telephone Number (###-###-####)	E-mail Address (required for online applicants)

Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female	Occupation

PHYSICIAN INFORMATION

Name of Hospital, University or Practice		
First Name	Middle Name	Last Name
Office Address		

Suite #	City	State IL	ZIP Code

Office Telephone Number (###-###-####)	E-mail Address (required for online applicants)

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CAREGIVER INFORMATION

If you would like to designate a caregiver, complete the following information and have your designated caregiver complete the designated caregiver application.

Drivers License # (if applicable):		Driver's License State (if applicable):	
First Name	Middle Name	Last Name	
Home Address			
Apartment or Suite #	City	State IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address (required for online applicants)		
Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female		

_____ _____

SIGNATURE of Designated Caregiver DATE (mm/dd/yyyy)

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Proof of residency
Attach a copy of any two of the following items:

- ❑ Pay stub or electronic deposit receipt issued less than 60 days prior to the date of application that shows evidence of the applicant's withholding for state income tax.
- ❑ Valid voter registration card with an address in Illinois.
- ❑ A valid, unexpired Illinois driver's license or other state identification card issued by the Illinois secretary of state.
- ❑ Notarized homeless status certification: https://www.cyberdriveillinois.com/publications/pdf_publications/dsd_a230.pdf
  - If you are using this form, you only need this document to prove residency.
- ❑ Bank statement, dated less than 60 days prior to application.
- ❑ Deed/title, mortgage, rental/lease agreement.
- ❑ Insurance policy (homeowner's or renter's).
- ❑ Medical claim or statement of benefits (from private insurance company or government agency), dated less than 90 days prior to application); Social Security Disability Insurance Statement; or Supplemental Security Income Benefits Statement.
- ❑ Tuition invoice/official mail from college or university, dated less than 12 months prior to application.
- ❑ Utility bill, including, but not limited to, those for electric, water, refuse, telephone land-line, cable or gas, issued less than 60 days prior to application.

Proof of identity and age
Attach one clear color photocopy of a U.S. or Illinois government-issued photo ID

Photograph
Attach a photograph that:

- was taken less than 30 days before application submission;
- was taken against a plain background or backdrop;
- is in natural color;
- was taken in full-face view directly facing the camera with a neutral facial expression and both eyes open (prescription glasses and religious head coverings not covering any areas of the open face are allowed);
- is at least 2 inches by 2 inches in size; and
- is at least 600 x 600 pixels, but no greater than 1,200 x 1,200 pixels in dimension.

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Physician Written Certification
Make sure your physician completes the Physician Written Certification Form and mails it to the Department's Division of Medical Cannabis.

Physician Written Certification for Veterans receiving care at a U.S. Department of Veterans Affairs (VA) Facility
Veterans receiving care at a VA facility do not need to provide a physician written certification, but must provide copies of the following forms:

- VA Form 10-5345 (U.S Department of Veterans Affairs, Request for and Authorization to Release Medical Records or Health Information) *If you have received care for your debilitating medical condition for more than 5 years at a VA facility, you must mark "OTHER" on VA Form 10-5345 under "INFORMATION REQUESTED" then specify that you are requesting information about the treatment of your debilitating medical condition for the most recent 12-month period. Under "PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED" write "personal medical purposes." Under "NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED" write your address. Once you receive your official medical records, you must submit the medical records with your application.*
- Form DD214 or equivalent certified documentation indicating character and dates of service.

Uniform Conviction Information Act (UCIA) Fingerprint Consent
Submit a copy of the UCIA fingerprint consent form. You may obtain a current listing of live scan fingerprint vendors from the Illinois Department of Financial and Professional Regulation website at https://www.idfpr.com/licenselookup/fingerprintlist.asp. Contact the live scan fingerprint vendor before going to get your fingerprints taken. When you go to get your fingerprints taken, remember to bring the UCIA Fingerprint Consent Form. Once you have your fingerprints taken, the UCIA Fingerprint Consent Form must be returned to the Department's Division of Medical Cannabis along with the completed patient application.

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Selection of medical cannabis dispensing organization

The qualifying patient must select one city, county or counties from the list below where they expect to obtain their medical cannabis. Once dispensaries are in place, the Department's Division of Medical Cannabis will ask registered qualifying patients to select a medical cannabis dispensing organization.

- ❑ District 1 – Carroll, Lee, Ogle and Whiteside counties
- ❑ District 6 - DeWitt, Livingston and McLean counties
- ❑ District 7 - Henry, Knox, Mercer and Rock Island counties
- ❑ District 8 - Marshall , Peoria, Stark, Tazewell and Woodford counties
- ❑ District 9 - Cass, Christian, Logan, Mason , Menard , Morgan and Sangamon counties
- ❑ District 10 - Champaign , Coles, Douglas, Edgar , Macon, Moultrie , Piatt, Shelby and Vermilion counties
- ❑ District 11 – Bond, Clinton, Madison , Monroe and St. Clair counties
- ❑ District 12 – Clark, Clay, Crawford , Cumberland , Effingham , Fayette, Jasper , Lawrence, Marion and Richland counties
- ❑ District 13 - Franklin , Jackson, Jefferson , Perry, Randolph , Washington and Williamson counties
- ❑ District 14 – Fulton, Hancock, Henderson, McDonough and Warren counties
- ❑ District 16 – Boone, Jo Daviess, Stephenson and Winnebago counties
- ❑ District 17 – Bureau, La Salle and Putnam counties
- ❑ District 18 - Calhoun , Greene, Jersey , Macoupin, Montgomery
- ❑ District 19 – Edwards, Gallatin, Hamilton, Saline, Wabash, Wayne and White counties
- ❑ District 20 – Adams, Brown, Pike, Schuyler and Scott counties
- ❑ District 21 – Ford, Iroquois and Kankakee counties
- ❑ District 22 – Alexander, Hardin, Johnson, Massac , Pope, Pulaski and Union counties
- ❑ DeKalb County
- ❑ DuPage County
- ❑ Grundy and Kendall counties
- ❑ Kane County
- ❑ Lake County
- ❑ McHenry County
- ❑ Will County
- ❑ Cook County, outside the city of Chicago
- ❑ City of Chicago

Application Fee

Include payment of the applicable fee by check, money order or credit card (online applicants only) payable to: **Illinois Department of Public Health**

Annual qualifying patient application fee: $100
Annual reduced qualifying patient application fee*: $50

*The reduced fee is for qualifying patients enrolled in the federal Social Security Disability Income (SSDI) or the Supplemental Security Income (SSI) disability programs. In order to verify enrollment in these programs, submit a copy of a letter or other documentation from the Social Security Administration identifying the qualifying patient and showing the amount of monthly Social Security and Supplemental Security Income disability benefits to be received by the qualifying patient during the current year of application.

*The reduced fee is for veterans who must provide a copy of their DD214.

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Certifications

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 Pilot 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 Pilot 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)

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Optional Demographic Information

Annually, the Illinois Department of Public Health is required to submit a report to the Governor and the Illinois General Assembly describing the implementation of the Compassionate Use of Medical Cannabis Pilot Program Act. The following demographic information will be compiled and used for this reporting. No individually identifiable information will be reported and this information will NOT be used for eligibility determination of the qualifying patient. This section is optional.

Marital Status – What is your current marital status?

❑ Single ❑ Separated ❑ Widowed
❑ Married/Civil Union ❑ Divorced ❑ Unmarried partnership

Household

How many people reside in your household, including yourself? _____

Does your household include children under 18 years of age? ❑ Yes ❑ No

Ethnicity - Which of the following best describes your ethnicity?

❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

Race – Which of the following best describes your racial heritage?

❑ Caucasian/White ❑ African American/Black ❑ Asian
❑ American Indian or Alaskan Native ❑ Native Hawaiian or Pacific Islande
❑ Other _____

Veteran Status – Are you a U.S. veteran? ❑ Yes ❑ No

Education – What is the highest level of education you completed?

❑ Did not complete high school ❑ Technical school
❑ High school diploma/GED ❑ University or 4-year college
❑ Community college/two-year degree ❑ Master's degree or above

Are you currently enrolled in school? ❑ Yes ❑ No

Employment – Are you currently employed? ❑ Yes ❑ No

❑ Full-time ❑ Part-time

What is your occupation? _____

Income – What is your annual household income?

❑ Less than $10,000 ❑ $20,000 to $24,999 ❑ $50,000 to $74,999
❑ $10,000 to $14,999 ❑ $25,000 to $34,999 ❑ $75,000 to $99,999
❑ $15,000 to $19,999 ❑ $35,000 to $49,999 ❑ $100,000 and above

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Optional Demographic Information (continued)

In addition to the primary debilitating medical condition indicated on your application, have you ever been told you have other chronic conditions? (choose all that apply)

- ❑ Arthritis
- ❑ Asthma
- ❑ COPD
- ❑ Diabetes
- ❑ High Blood Pressure/Hypertension
- ❑ Overweight/Obesity Height_____ Weight _____

Have you previously used medical cannabis? ❑ Yes ❑ No

Have you received education on the use of medical cannabis? ❑ Yes ❑ No

Do you intend to use medical cannabis edibles? ❑ Yes ❑ No

The following questions are related to disability.

Do you have health problems that require you to use special equipment, such as a cane, wheelchair, medical bed or a special telephone?

❑ Yes ❑ No

Are you limited in any activities because of physical, mental or emotional problems? ❑ Yes ❑ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses? ❑ Yes ❑ No

Do you have serious difficulty walking or climbing stairs? ❑ Yes ❑ No

Do you have difficulty dressing or bathing? ❑ Yes ❑ No

Because of a physical, mental or emotional condition, do you have difficulty doing errands, such as visiting a doctor's office or shopping?

❑ Yes ❑ No

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