**State of Illinois**
Illinois Department of Public Health

QP

Illinois Medical Cannabis Pilot Program

# Application for Qualifying Patient Registry Identification Card

**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 Number is QP._____.

## 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 | | |
| Are you an active duty law enforcement officer, correctional officer, correctional probation officer or firefighter? ❑ Yes ❑ No | Do you have a school bus permit or a Commercial Driver's License? ❑ Yes ❑ No | | |

## PHYSICIAN INFORMATION

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

## MEDICAL CANNABIS DISPENSARY SELECTION

| 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.



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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 OF QUALIFYING PATIENT _____ DATE (mm/dd/yyyy) _____

## APPLICATION FEES

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

Annual qualifying patient application fee . . . . . $100

Annual reduced qualifying patient application fee* . . . . . $50

Annual designated caregiver application fee. . . . . $25

*The reduced fee is for qualifying patients enrolled in the Federal Social Security Disability Income (SSDI), Supplemental Security Income (SSI) disability programs, or Veterans.

Patients enrolled in SSDI or SSI – Submit a "Benefit Verification Letter" from the Social Security Administration that shows your name and address and the type of benefits that are received. This letter must be dated within the last year. You can get this letter by using your My Social Security account online at https://www.ssa.gov/myaccount/ or calling the Social Security Administration at 1-800-772-1213. Annual cost of living increase letters will not be accepted as proof because they do not show the type of benefits received.

Veterans – Submit a copy of your DD-214 showing dates of service and character of service (type of discharge).

**APPLICATION FEES ARE NOT REFUNDABLE**



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# Fingerprint Consent Form
# Medical Cannabis Registry Identification Card

Pursuant to the Compassionate Use of Medical Cannabis Pilot Program Act, applicants for a Medical Cannabis Registry Identification Card must have a UCIA fingerprint-based criminal history record information background check. The Illinois Department of Public Health will comply with rules and regulations concerning your criminal background check authorized by the Compassionate Use of Medical Cannabis Pilot Program Act (410 ILCS 130) and the UCIA (20 ILCS 2635). This form captures the information required by licensed live scan fingerprint vendors to ensure your fingerprints are submitted properly. A transaction control number (TCN) will be issued by the live scan fingerprint vendor at the time of transmission of fingerprints. The TCN is verification your prints were taken and the vendor must fill in the TCN on this consent form. The live scan vendor will use the applicant information to help confirm your identification documentation before the fingerprints are taken. This document also serves as your consent form. The form must be signed in order to authorize the release of any criminal history record information that may exist. The results of the criminal history background check will be forwarded to the Illinois Department of Public Health for review.

## Facility Information

| Requesting Agency ORI Identifier: | Purpose Codes: |
|---|---|
| LG1407112 | ❑ MMP Medical Marijuana Patient<br>❑ MMP Medical Marijuana Caregiver |
| Requesting Agency Name and Address: | |
| Illinois Department of Public Health, 535 West Jefferson Street, Springfield, Illinois, 62761-0001 | |
| Contact Person Name: | Contact E-mail and Phone #: |
| Division of Medical Cannabis | DPH.MedicalCannabis@illinois.gov and 217-782-3300 |
| Facility Cost Center (If any):<br>*Note: Cost is responsibility of the applicant* | Transaction Control Number (TCN): |

## Applicant Information

| Name: | Sex:<br>Select | Race: | Date of Birth (mm/dd/yyyy): |
|---|---|---|---|
| SSN (optional): | Drivers License #: | | Driver's License State: |

## Livescan Vendor/Appointment Information

| Live Scan Fingerprint Vendor Name: | Address: | |
|---|---|---|
| Phone Number: | Appointment Date: | Appointment Time: |

## Privacy Statement

I, the undersigned, hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution or entity having such information on file. I am aware and understand my fingerprints may be retained and will be used to check the criminal history record information files of the Illinois State Police and/or the Federal Bureau of Investigation where permitted by law. I also understand if my photo was taken, my photo may be shared only for employment or licensing purposes. I further understand I have the right to challenge any information disseminated from these criminal justice agencies regarding me that may be inaccurate or incomplete pursuant to Title 28 Code of Federal Regulation 16.34 and Chapter 20 ILCS 2630/7 of the Criminal Identification Act.

## Applicant Consent

| Applicant Name (printed): | Date: |
|---|---|
| Applicant Name (signature): | Date: |



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## REQUIRED DOCUMENTS

| | |
|---|---|
| | **Place the following items in an envelope and attach to fingerprint consent form:** |
| ❑ | **Non-refundable application fee (Check or Money Order to Illinois Department of Public Health)** |
| ❑ | **Photograph**<br>• Taken in the last 30 days<br>• Taken against a plain, white or off-white background or backdrop<br>• In natural color (Do not use a filter)<br>• Full-face view directly facing the camera with a neutral facial expression and both eyes open<br>• At least 2 inches by 2 inches in size<br>It is recommended you use a passport photo vendor to ensure the photograph meets these requirements.<br>Contact the Division of Medical Cannabis if a photograph is in violation of or contradictory to the qualifying patient's religious convictions. |
| | **Attach the following supporting documents to the fingerprint consent form:** |
| ❑ | **Proof of age and identity**<br>Submit a clear, color copy of an Illinois Driver's License, Illinois State ID, or the photograph page of a US passport. |
| ❑ | **Proof of residency**<br>If your Driver's License or State ID address matches your application submit one additional proof of residency. If you submit a US Passport as your proof of identity or your Driver's License or State ID address does not match the address on your application, submit two of the following:<br>• 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<br>• Valid Voter Registration card<br>• Deed/title, mortgage, rental/lease agreement<br>• Insurance policy (homeowner's or renter's)<br>• 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 States.<br>• Tuition invoice/official mail from college or university, dated 12 months prior to application<br>• 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<br>• Notarized homeless status certification: https://www.cyberdriveillinois.com/publications/pdf_publications/dsd_a230.pdf<br>○ If you are using this form, you only need this document to prove residency<br>Proof of residency must include name and address and match the address on the application |
| ❑ | **Fingerprint receipt**<br>A listing of live scan fingerprint vendors can be found at https://www.idfpr.com/LicenseLookUp/fingerprintlist.asp. Contact the live scan fingerprint vendor before having fingerprints taken to make sure they take Medical Cannabis fingerprints. Remember to bring the fingerprint consent form to the vendor and add the Transaction Control Number (TCN) to your form. Once you have your fingerprints taken, the fingerprint consent form and the receipt provided by the live scan fingerprint vendor containing the TCN must be sent in with your application. Fingerprints must be taken within 30 days of submitting your application. |
| ❑ | **Benefit Verification Letter from the Social Security Administration or DD-214 (if applicable)** |

**Mail the application and required documents to:**

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


**DO YOU NEED A CAREGIVER TO ASSIST WITH THE USE OF MEDICAL CANNABIS?**

**To designate a caregiver now, complete the Designated Caregiver Application and submit the required documents with your patient application.**

Questions? Contact the Division of Medical Cannabis at 855-636-3688 or DPH.MedicalCannabis@Illinois.gov.



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