

**Maine Medical Use of Cannabis Program Trip Ticket**

The following information is required as proof of authorized conduct anytime a registered caregiver, registered dispensary, cannabis testing facility, or manufacturing facility transports cannabis or cannabis products for medical use. This form must accompany the cannabis or cannabis products. For more information: <https://www.maine.gov/dafs/omp/medical-use/applications-forms>.

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| **SECTION 1: Transferring Registrant**This section must be completed by the transferring registrant. |
| Caregiver’s Legal Name | Caregiver (CRG) Registry Identification Card Number |
| Legal Name of Dispensary Registration Certificate Holder, if applicable | Dispensary (DSP) Registration Certificate Number, if applicable |
| **SECTION 2: Receiving Patient or Registrant**This section must be completed anytime cannabis or cannabis products for medical use are transported, including patient delivery and when a registered caregiver, registered dispensary, cannabis testing facility, or manufacturing facility is transporting cannabis or cannabis products from one of its registered locations to a different registered location.This section must be completed by the transferring registrant. |
| Patient Identification Number/Medical Certification Number (DO NOT LIST NAME) |
| **OR** |
| Caregiver’s Legal Name | Caregiver (CRG) Registry Identification Card Number |
| Legal Name of Dispensary Registration Certificate Holder, if applicable | Dispensary (DSP) Registration Certificate Number, if applicable |
| **SECTION 3: Description of Cannabis or Cannabis Products Transported**For each item transported, provide the amount (weight or units), product type (flower, wax, cartridges, etc.), and strain or other further identifying information of the cannabis or cannabis products. This section must be completed by the transferring registrant. |
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| **SECTION 4: Departure Information**This section must be completed by the transferring registrant. |

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| Start Date | Start Time |
| Departure Address (Physical) | City |  State Maine |  ZIP  |
| **SECTION 5: Destination Information**This section must be completed by the transferring registrant. |
| Destination Address (Physical) | City |  State Maine |  ZIP  |
| **SECTION 6: Receiving Registration Signature and Acknowledgment of Receipt** This form is incomplete without a signature by the receiving registrant listed in Section 2. If the person listed in Section 2 is a patient, no signature is required.This section must be completed by the receiving registrant. |

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| Printed Name of Receiving Registrant | Email Address | Phone Number |
| Date Received | Time Received  |
| Signature |