



Medical Use of Marijuana Program Caregiver Application/Renewal Form

Check one:

Nursing Facility

Hospice

Primary Caregiver
(Not growing marijuana)

Primary Caregiver
(Growing marijuana)

Section 1. Caregiver Information

Name (as it appears on driver license)

Date of birth: _____

Attach copy of current Maine Driver License or Other
Maine Issued Photographic Identification Card

Home Address

(number, apartment number and street name)

(city, state, zip code)

Mailing address (if different from above)

(number, apartment number and street name)

(city, state, zip code)

Telephone (207)

Email address:

Section 2 (if applicable) Completed by Nursing Facility or Hospice Chief Executive Officer

Check One: Nursing Facility Hospice Provider

Name of Facility (as it appears on state license)

Mailing Address

Name and Title of Chief Executive Officer:

Telephone Number (207)

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------|----------------------|
| Email Address of Chief Executive Officer: | | | |
| LIST ALL EMPLOYEES who will assist the patient with the medical use of marijuana. Each employee must secure a registry identification card from the Department. | | | |
| Name | Title | Driver License # | Date of birth |
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Section 3 If applicable, GROW LOCATION (Completed by Cultivating Caregiver)

Address/grow location (street, apartment, city, state, zip code)

Enclosed, locked facility means a closet, room, building, greenhouse or other enclosed area that is equipped with locks or other security devise that permit access only by an individual authorized to cultivate the marijuana.
Describe how your grow location meets this requirement:

Prepared Edibles. Indicate whether you will prepare edibles containing marijuana: yes no
If yes, have you met the requirements for a food establishment? yes no. (If yes please attach evidence.)
If no, please indicate why not.

Section 4 If applicable, CAREGIVER EMPLOYEE (only one employee per cultivating caregiver)

You are permitted to employ *one* individual to assist you in cultivation of marijuana as a registered caregiver, regardless of the number of patients who have designated you to grow their marijuana. You must register your employee with the Department to secure a registry identification card for the employee. The Department shall complete a criminal back ground check and issue a card if the prospective employee has no disqualifying criminal conviction and meets all other requirements.

| | |
|-------------------------|-----------------------|
| Name of employee | Date of birth: |
|-------------------------|-----------------------|

Address of employee (street, apartment, city, state zip)

Section 5. FEES

1. I am a caregiver who does not grow marijuana (No fee) ___ Yes ___ No
2. I am applying to grow for (number) _____ patients. (maximum of 5 qualifying patients)
3. I have enclosed the cultivation fee of \$300 per patient for a total of \$_____
4. I have enclosed the \$31.00 for a caregiver criminal background check. ___ Yes ___ No
5. I have enclosed the \$31.00 for my cultivation employee. ___ Yes ___ No
6. **TOTAL ENCLOSED \$** _____
Do not send cash. Credit Cards are not accepted. Make check or money order payable to: Treasurer, State of Maine

Section 6. DECLARATION

- I UNDERSTAND and acknowledge my duties as a caregiver.
- I UNDERSTAND that my authorization to grow marijuana is contingent on my possessing a valid caregiver designation form for each patient for whom I grow marijuana.
- I AGREE TO RETURN the caregiver designation form to the patient if the patient informs me that he or she no longer wants me to be his or her caregiver.
- I ACKNOWLEDGE that I have only 10 days from that notice to either destroy excess marijuana or to replace the patient with a new patient.
- I AGREE that in the event law enforcement questions my status as a caregiver, that I will make available for verification to law enforcement, copies of each caregiver designation form that I rely on to support the amount of marijuana in my possession.
- I UNDERSTAND that if I do not comply with any of these requirement, the Department of Health and Human Services can revoke the caregiver identification card assigned for that patient.
- I DECLARE under penalty of perjury that the information provided on this form is true and correct.
- I CERTIFY that I will not sell, furnish or give marijuana to a person who is not allowed to possess marijuana for medical purposes.
- I FURTHER AGREE that I will report sales tax related to the sale of marijuana by me to a qualifying patient .

Print Name of Caregiver: _____

Signature of Caregiver: _____ **Date:** _____