



STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Maine Center for Disease Control and Prevention
Medical Use of Marijuana Program
Primary Caregiver Application

| | | | | | |
|---|--|--------|--|----------------------------------|--|
| SECTION 1: Primary Caregiver Information | | | New Applicant <input type="checkbox"/> | Renewal <input type="checkbox"/> | Adding Patient (Max of 5) <input type="checkbox"/> |
| Legal Name: | | | | | |
| Date of Birth: (Must be at least 21) | | | Telephone Number: () | | |
| Home Address: | | | | | |
| City: | | State: | | Zip: | |
| Mailing Address: | | | | | |
| City: | | State: | | Zip: | |
| Email Address: | | | SSN or Federal Identification Number: | | |

| | |
|---|--|
| SECTION 2: Fees | |
| <input type="checkbox"/> Nursing Facility Name of Facility: _____ <input type="checkbox"/> Hospice Name of Facility: _____ <input type="checkbox"/> Non Cultivating Primary Caregiver- Mandatory \$31 fee for background checks <input type="checkbox"/> Primary Caregiver (cultivating marijuana) – Please complete below: Number of patients (maximum of 5): _____ multiplied by \$240 cultivation fee = Caregiver Criminal Background Check: \$31.00 (Mandatory Annually) | \$ _____ \$ _____ \$ _____ |
| <p>The exceptions for the \$240 cultivation fee are found in the Rules Governing the Maine Medical Use of Marijuana Program Section 5.4 If one of the exceptions apply, please identify the patient/caregiver relationship _____ All Fees are non-refundable (Section 7.1 MMMP rules)</p> | |
| <p>Make bank check or money order payable to "Treasurer, State of Maine". We are unable to accept personal checks, cash and credit cards.</p> | |
| Total Bank Check/Money Order enclosed: | \$ _____ |

Submit completed application and applicable fees to the following address:

Department of Health and Human Services
 Maine Center for Disease Control and Prevention
 Maine Medical Use of Marijuana Program
 286 Water Street 11 State House Station
 Augusta, ME 04333-0011

Tel: (207) 287-8016

Fax: (207) 287-2671

TTY users: Dial 711 (Maine relay)

Email: DHHS.MMMP@maine.gov

Website: www.mainepublichealth.gov/mmm

| | | |
|------------------|-----------------|-----------------|
| Office Use Only: | | |
| Check/MO # _____ | Amount \$ _____ | Initials: _____ |

SECTION 3: Cultivation Location

Street Address:

| | | | |
|-------|--------|------|---------|
| City: | State: | Zip: | County: |
|-------|--------|------|---------|

 Indoor: Please describe **Outdoor: Please describe****If you do not own the property where you will be cultivating medical marijuana, please complete the following:**

Legal Name of Property Owner:

Home Address:

| | | | |
|-------|--------|------|---------|
| City: | State: | Zip: | County: |
|-------|--------|------|---------|

SECTION 4: Submission

Remember to submit the following documents with your completed application:

- A bank check or money order made payable to **“Treasurer, State of Maine”**
- Copy of the Caregiver’s current Maine Driver’s License or Other Maine Issued Photographic Identification Card

SECTION 5: Declaration

- I UNDERSTAND and acknowledge my duties as a primary caregiver.
- I UNDERSTAND that my authorization to cultivate medical marijuana is contingent on my possessing a valid caregiver designation form for each patient for whom I grow medical marijuana.
- I AGREE to comply with the applicable regulations and requirements if I am producing edibles with medical marijuana or using pesticides in the cultivation of medical marijuana.
- I AGREE to return the designation form and designation card 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 lawfully dispose excess marijuana or to replace the patient with a new patient.
- I AGREE that in the event that law enforcement questions my status as a primary caregiver, I will make available for verification to law enforcement, copies of each caregiver designation form upon which I rely on to support the amount of medical marijuana in my possession.
- I UNDERSTAND that if I do not comply with these requirements, the Department of Health and Human Services may revoke authorization to serve as a primary caregiver under the Maine law.
- I DECLARE under penalty of perjury that the information provided on this form is true and correct.
- I UNDERSTAND that I must submit a new primary caregiver application each time I apply for a card and/or renew a card.
- 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 UNDERSTAND that I may employ only one person to assist in performing the duties of the primary caregiver.
- I UNDERSTAND that my employee must register with the State of Maine in accordance with state law.
- I ACKNOWLEDGE that I have provided my social security number or federal identification number for reporting to the Maine Revenue Services for tax purposes only.
- I FURTHER AGREE that I will report sales tax related to my sale and transactions of medical marijuana.

Print Name of Primary Caregiver_____
Signature of Primary Caregiver_____
Date