STATE OF MAINE
DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES
BUREAU OF BUSINESS MANAGEMENT

Medical Use of Marijuana Program

Designation Form

Minors, Family Members, Household Members & Visiting Patients must designate

SECTION 1: Patient Information: ☐ **Maine qualifying patient** ☐ **Visiting qualifying patient**		
Legal Name:		
Date of Birth:	Telephone Number: ( )	
Home Address:		
City:	State:	Zip

☐ Maine Medical Provider Written Certification Random ID Number: _____

Issued Date: _____ Expiration Date: _____

☐ Visiting qualifying patient:

Home state issued date: _____ Home state expiration date: _____

Maine form provider signature date: _____ Maine form expiration date: _____

SECTION 2: Cultivation Designation:

_____ # of plants I will cultivate (visiting qualifying patients may not cultivate)

_____ # of plants my caregiver will cultivate (must be at least 1)

_____ # of plants my dispensary will cultivate (must be at least 1)

Total # (Not to exceed 6) _____

A long-term care facility may not cultivate marijuana plants for the patient.

Maine Medical Use of Marijuana Program (MMMP)
162 State House Station
Augusta, ME 04333-0162
Tel: (207) 287-9330 or 287-3282 Fax: (207) 287-2671 TTY users: Dial 711 (Maine relay)

E-mail dhhs.mmmp@maine.gov Website: www.maine.gov/dafs/bbm/mmmp/

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SECTION 3A: Cultivating Caregiver Information		
Legal Name:		Telephone Number: ( )
Mailing Address:		
City:	State:	Zip:
Caregiver is not required to register: Specify exception: _____		
Start Date:	End Date:	Termination Date:

SECTION 3B: Non-Cultivating Caregiver Information (Pick up and/or administer)		
Legal Name:		
Telephone Number: ( )		
City:	State:	Zip:
Caregiver is not required to register: Specify exception: _____		
Start Date:	End Date:	Termination Date:

SECTION 4: Dispensary Information:		
Name of Dispensary:		
Physical Address:		Telephone Number: ( )
City:	State:	Zip:
Name of Dispensary Representative:		
Start Date:	End Date:	Terminations Date:

SECTION 5: Long-Term Care Facility Information:		
Name of Facility:		
Physical Address:		Telephone Number: ( )
City:	State:	Zip:
Start Date:	End Date:	Terminations Date:

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SECTION 6A: Maine Qualifying Patient and/or Parent/Guardian Responsibilities

☐ Maine Patient (Minors, Family members & Household members must designate

My provider has certified that as a patient, I am likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate my medical diagnosis. I have provided you with the following for your records:

1. My **original** designation card.
2. A copy of my certification.
3. A copy of my government issued photo ID or birth certificate.

SECTION 6B: Visiting Qualifying Patient Responsibilities

☐ Visiting Patient (must designate)

My provider has certified that I live in a state that authorizes marijuana for medical purposes. I have provided you with the following for your records:

1. A copy of my certification from my home State of _____.
2. A copy of the visiting qualifying provider certification provided by Maine.
3. A copy of my photo identification card or driver's license issued by my home-jurisdiction.

SECTION 7: Attestation

I have read and attest to the following:

- You are hereby authorized to share this designation form and any copies of documents that I am required to provide, to a member of law enforcement, MMMP staff and/or their representatives in order to verify the services you are providing to me are authorized under Maine law.
- I have the right to terminate this agreement at any time. This designation form and designation card is my property, and any authorized activity conveyed to you through this designation form terminates upon my notice.

_____	_____	_____
Patient/Guardian Name-Print	**Patient/Guardian Name-Signature**	**Date**
_____	_____	_____
Designee Name-Print	**Designee Name-Signature**	**Date**