OFFICE OF CANNABIS POLICY
DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES

MAINE MEDICAL USE OF CANNABIS PROGRAM DESIGNATION FORM

SECTION 1: Patient Information

Patient's Legal Name:		
Date of Birth:	Telephone Number: ( )	
Home Address:		
City:	State:	Zip

❑ Maine Medical Use of Cannabis Patient

Patient Certification Random Identification Number: _____

Issued Date: _____ Expiration Date: _____

❑ Visiting Qualifying Patient

Home State: _____ Medical Cannabis Credential Id Number: _____

Issued Date: _____ Expiration Date: _____

SECTION 2: Cultivation Designation (if applicable)

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

Number of plants my caregiver will cultivate: _____

Number of plants my dispensary will cultivate: _____

Total number of plants (not to exceed 6): _____

Please note: A long-term care facility may not cultivate cannabis plants for a patient.

SECTION 3A: Cultivating Caregiver Information

Legal Name:		Telephone Number: ( )
Mailing Address:		
City:	State:	Zip:

☐ Caregiver is not required to register: Specify exception: _____

Number of Mature Plants: _____ Number of Immature Plants: _____

Start Date:	End Date*:	Termination Date:

*End Date cannot exceed the expiration date of qualifying patient's written certification.

SECTION 3B: Non-Cultivating Caregiver Information (pick up and/or administer)

Legal Name:		Telephone Number: ( )
Mailing Address:		
City:	State:	Zip:
☐ Caregiver is not required to register: Specify exception: _____		
Start Date:	End Date*:	Termination Date:
*End Date cannot exceed the expiration date of qualifying patient's written certification.		

SECTION 4: Dispensary Information

Name of Dispensary:		
Physical Address:		Telephone Number: ( )
City:	State:	Zip:
Name of Dispensary Representative:		
Start Date:	End Date*:	Terminations Date:
*End Date cannot exceed the expiration date of qualifying patient's written certification.		

SECTION 5: Long-Term Care Facility Information

Name of Facility:		
Physical Address:		Telephone Number: ( )
City:	State:	Zip:
Start Date:	End Date*:	Terminations Date:
*End Date cannot exceed the expiration date of qualifying patient's written certification.		

SECTION 6: Maine Qualifying Patient and/or Parent/Guardian & Designee Attestation

Patient has provided the following:

1. A copy of patient certification.
2. A copy of patient government issued photographic ID or birth certificate.

We have read and attest to the following:

- You are hereby authorized to share this designation form and any copies of documents that we are required to provide, to a member of law enforcement, Office of Cannabis Policy staff and/or their representatives in order to verify the services you are providing to me are authorized under Maine law.
- Patient has the right to terminate this agreement at any time. This designation form and the patient certification are the patient's property, and any authorized activity conveyed to you through this designation form terminates upon patient's notice.

Patient or Parent/Guardian Printed Name	Patient or Parent/Guardian Signature	Date
Designee Printed Name	Designee Signature	Date