STATE OF MAINE
Office of Marijuana Policy
Medical Use of Marijuana Program
Designation Form

Minors, Family Members, Household Members and 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 Use of Marijuana Patient

Patient Certification Random Identification Number: _____

Issued Date: _____ Expiration Date: _____

☐ Visiting Qualifying Patient

Home State: _____

Medical Marijuana/Cannabis Credential Identification 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 (must be at least 1): _____

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

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

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

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:

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

☐ Maine Patient (Minors, Family Members and 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. A copy of my certification.
2. A copy of my government-issued photographic identification or birth certificate.

SECTION 6B: Visiting Qualifying Patient Responsibilities

☐ Visiting Patient (Must designate.)

My designee 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.
2. 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:

A. 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, Office of Marijuana Policy staff and/or their representatives in order to verify the services you are providing to me are authorized under Maine law.

B. 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.

Signature - This application cannot be accepted without a signature.

I have read and understand the statements above.

Patient/Guardian's Name (Please print.)	Patient/Guardian's Signature	Date
Designee's Name (Please print.)	Designee's Signature	Date

Medical Use of Marijuana Program
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