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

Medical Use of Marijuana Program

Designation Form

SECTION 1: Qualifying Patient Information			
Legal Name:			
Date of Birth:		Telephone Number: ( )	
Home Address:			
City:	State:	Zip:	County:
Medical Provider Written Certification: Issued Date: _____		Expiration Date: _____	

SECTION 2: Cultivation Designation

_____ # of plants I will cultivate

_____# of plants my caregiver will cultivate

_____# of plants my dispensary will cultivate

Total # (Not to exceed 6) _____

☐ Visiting qualifying patient (must be included as 1 of the 5 patients allowed per caregiver)

☐ Non cultivating caregiver

A patient may designate either a primary caregiver or a dispensary to cultivate

For questions regarding this program, please contact the following:
Department of Administrative & Financial Services
Bureau of Business Management
Maine Medical Use of Marijuana Program
#162 State House Station
Augusta, ME 04333-0162

Tel: (207) 287-3282 or 287-9330 Fax: (207) 287-2671 TTY Users: Dial 711 (Maine Relay)

Email: dhhs.mmmp@maine.gov
Website: www.mainepublichealth.gov/mmm

SECTION 3A: Cultivating Caregiver Information			
Legal Name:			
Telephone Number: ( )			
Mailing Address:			
City:	State:	Zip:	County:
Caregiver MMMP Registration # assigned to this patient: ☐ Primary Caregiver is not required to register: Specify exception:			
Start Date:	End Date:	Termination of Designation Date:	

SECTION 3B: Non Cultivating Caregiver Information			
Legal Name:			
Telephone Number: ( )			
Mailing Address:			
City:	State:	Zip:	County:
Caregiver MMMP Registration # assigned to this patient: ☐ Primary Caregiver is not required to register: Specify exception:			
Start Date:	End Date:	Termination of Designation Date:	

SECTION 4: Dispensary Information		
Name of Dispensary:		
Physical Address:	Telephone Number: ( )	
Name of Dispensary Representative:		
Start Date:	End Date:	Termination of Designation Date:

SECTION 5: Patient Rights and Responsibilities

- My provider has certified that I have a condition that entitles me to participate in the Maine Medical Use of Marijuana Program until _____. **I have provided you with 1. A copy of my Maine Medical Use of Marijuana Program identification card/MMMP certification, 2. my original designation card as proof that I am authorized to participate in the program and 3. a copy of my Maine issued driver license or other Maine issued photo identification card as proof of my identity.**
- If I am visiting from another state, I have provided you with a copy of the medical use of marijuana certification issued by my state of _____ as evidence that I live in a state that authorizes marijuana for medical purposes and have a debilitating condition authorized under Maine law. I have also provided you with a copy of my Maine provider certification and a copy of my photographic identification card or driver's license from my home jurisdiction. As a visiting qualifying patient, I agree to abide by all terms and conditions of the Maine Medical Use of Marijuana Program.

You are hereby authorized to share this caregiver designation form and any copies of documents that I am required to provide to a member of the law enforcement community and MMMP Staff/Investigators 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 MMMP designation form and designation card is my property, and any authorized activity conveyed to you through this designation form terminates upon my notice. You must either dispose of the excess marijuana in your possession on my behalf, or replace me with another qualified patient. You will have 10 days from the date of notice to return this form to me.

In the event I terminate this agreement and you do not return this designation form to me, I authorize the Maine Department of Health and Human Services to demand the return of this designation form and card or take other action to enforce the Rules Governing the Maine Medical Use of Marijuana Program, which includes terminating the caregiver number that they assigned to you and that you have listed on this designation form.

_____	_____	_____
Print name of patient/guardian	**Signature of patient/guardian**	**Date**
_____	_____	_____
Print name of designee	**Signature of designee**	**Date**

Numeric identification assigned by the designee: _____