



# Iowa Department of Public Health

## Additional Primary Caregiver Registration Card Application

This form should be used after the patient has received the recommendation from the treating neurologist and the patient or his or her parent/legal guardian has received the official approval notice from the Iowa Department of Public Health. This form is used to request approval for a registration card for an additional primary caregiver that was not included as a part of the original application.

The form must be fully completed to be considered for approval by the Iowa Department of Public Health. If the form is not complete, the applicant will be contacted for the missing information. This form must be signed by the patient or the patient’s parent or legal guardian if the patient is under 18 years of age.

This form must be mailed to: Iowa Department of Public Health  
c/o MCA Registration Card Program  
Lucas State Office Building  
312 E. 12<sup>th</sup> Street  
Des Moines, IA 50319-0075

### SECTION I. PATIENT INFORMATION *(please print)*

Patient Name: \_\_\_\_\_  
(first) (middle) (last)

Date of Original Application Approval Provided by the Iowa Department of Public Health on mailed notice:

\_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_  
(month) (day) (year)

#### **PATIENT CERTIFICATION**

I certify that all information provided by me on this application is true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand that I am required to know and comply with the provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card.**

Signature of patient, if age 18 or older: \_\_\_\_\_

Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_

Signature of parent or legal guardian, if patient is under age 18: \_\_\_\_\_

Printed name of parent or legal guardian: \_\_\_\_\_

Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_

Patient Name: \_\_\_\_\_

**SECTION II. ADDITIONAL PRIMARY CAREGIVER INFORMATION** *(please print)*

Name: \_\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_  
(street and number)

\_\_\_\_\_  
(city) (state) (zip code)

Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ Sex: \_\_ Male \_\_ Female  
(month) (day) (year)

Telephone Number: ( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

**Valid Photo Identification:** Attach a copy of the Primary Caregiver’s valid photo identification.

**APPLICANT - PRIMARY CAREGIVER - CERTIFICATION**  
I have been designated by the patient’s neurologist or by a person having custody of the patient as being necessary to manage the well-being of the patient with respect to the medical use of cannabidiol pursuant to Iowa Code chapter 124D, and I am willing and able to serve in this capacity. I certify that the foregoing statements and all information provided by me on this application are true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand I am required to know and comply with provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card.**  
Signature: \_\_\_\_\_ Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_