



MEDICAL CANNABIDIOL REGISTRATION CARD – PRIMARY CAREGIVER APPLICATION

For adult patients, they must also complete the adult patient application. For minor patients, this primary caregiver application must include the minor’s parent or legal guardian name(s) and contact information.

We now accept electronic applications!
 For online submission of registration applications, go to <https://idph.iowa.gov/cbd>
 For paper applications, mail completed application and required materials to:
Iowa Department of Public Health ATTN: OMC 321 E. 12th Street Des Moines, IA 50319-0075

PRIMARY CAREGIVER INFORMATION

“Primary Caregiver” means a person, who is a resident of Iowa or a bordering state, including but not limited to a parent or legal guardian, at least eighteen years of age, who has been designated by a patient’s health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol.

New Caregiver Renewing Caregiver

Name
(First, Middle Initial, Last)

Sex Designation <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Must be 18 or Older)
County where you live	
Where You Live	Permanent Iowa Address (Street, Apt. #)
	Address (City, State ZIP Code)
Where You Get Mail	Address (P.O. Box, Apt. #)
	Address (City, State ZIP Code)
Primary Phone Number	<input type="checkbox"/> Check this box if a confidential message may be left at this number.
Secondary Phone Number	<input type="checkbox"/> Check this box if a confidential message may be left at this number.
E-Mail Address	

PRIMARY CAREGIVER ATTESTATION STATEMENT

PRIMARY CAREGIVER INSTRUCTION: Complete and sign the following release statement. This statement will allow the Office of Medical Cannabidiol staff to verify information with the certifying physician(s) relating to the patient’s qualifying debilitating medical condition, and the dispensing of cannabidiol related to that condition. It will also allow the Office to complete the processing of your application and issuance of your Medical Cannabidiol Registration Card.

I, _____, (primary caregiver), hereby authorize the Iowa Department of Public Health (IDPH), Office of Medical Cannabidiol, to exchange information about the patient’s qualifying debilitating medical condition with his or her certifying health care practitioner, the Iowa-licensed medical cannabidiol dispensaries, and the Department of

Transportation in relation to the issuance of a Medical Cannabidiol Registration Card and the dispensing of any cannabidiol/cannabinoid product.

By signing below, I certify that the information on this application is complete, true and submitted for the purpose of obtaining a State of Iowa Medical Cannabidiol Registration Card. If approved for the Registration Card, I agree to the terms of the Iowa Medical Cannabidiol Act, Chapter 124.E. A copy of the act may be found at this web address: <https://idph.iowa.gov/mcarcp>

- **To ensure confidentiality, information regarding application status will not be given over the phone.** Once applications are processed, communication will be sent to your residence with further instructions for the finalization of the Registration Card.
- You are required by law to notify the Iowa Department of Public Health Office of Medical Cannabidiol with any changes of information within 10 days of the change.
- Any Registration Card that is lost or stolen must be reported to the Office of Medical Cannabidiol immediately.
- Applicant information changes that are printed on the Registration Card (such as name or address) will require a new card to be issued.

_____ Initial	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
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_____ Initial	I agree to notify the Office of Medical Cannabidiol, in writing, within 10 days of any change to the information provided.
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_____ Initial	I have not been convicted of a disqualifying felony offense which is a violation under federal or state law of a felony under federal or state law, which has as an element the possession, use or distribution of a controlled substance, as defined in 21 U.S. C. §802 (6).
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I certify under penalty of perjury that all of the 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 Medical 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 Medical Cannabidiol Registration Card.**

Caregiver Signature	Date of Signature
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PATIENT INFORMATION

Patient Name
(First, Middle Initial, Last)

Sex Designation Male Female

**Patient
Date of Birth**

Age

Patient's Permanent Iowa Address:
(Street, Apt. #)

Patient's Address:
(City, State ZIP Code)

For Patients under Age 18 (Name of Patient's Parent or Legal Guardian will be printed on the Primary Caregiver Card.)

**Name of Patient's
Parent or Legal Guardian**

Caregiver Signature	Date of Signature
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PRIMARY CAREGIVER APPLICATION CHECKLIST

Primary Caregiver

Applicant Name

(First, Middle Initial, Last)

PRIMARY CAREGIVER INFORMATION AND ATTESTATION SECTION

I have signed, dated and initialed all areas of this application in the PRIMARY CAREGIVER ATTESTATION SECTION.

PATIENT INFORMATION SECTION

The patient's information is provided in the PATIENT INFORMATION SECTION.

If the patient is under age 18, the name of the patient's parent or legal guardian is provided in this section.

HEALTH CARE PRACTITIONER and MEDICAL CONDITION CERTIFICATION

The patient's health care practitioner has completed the HEALTH CARE PRACTITIONER CERTIFICATION and certified that the patient has one or more of the qualifying debilitating medical conditions. It is attached to this application.

APPLICANT - PRIMARY CAREGIVER - DOCUMENTATION

For Iowa resident applicants: A clear copy of the primary caregiver applicant's valid photo identification card is attached.

A valid Iowa driver's license

A valid Iowa non-operator's identification card

For applicants who are not a resident of the state of Iowa: A clear copy of the primary caregiver applicant's valid photo identification card is attached.

A valid state-issued driver's license or nonoperator's identification card issued by a state other than Iowa

An alternate form of valid photo identification. (If the applicant is ineligible to obtain a driver's license or a non-operator's identification card may apply for an exemption and request submission of an alternative form of valid photo identification. An applicant who applies for an exemption is subject to verification of the applicant's identity through a process established by the Iowa Department of Public Health and the Department of Transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.)

APPLICATION FEE

Cash or check in the amount of the application fee is attached. **Primary Caregiver Application Fee - \$25**

Fee Included: **\$25** (A check should be made out to "Iowa Department of Public Health." Cash will also be accepted.)