**IOWA DEPARTMENT OF PUBLIC HEALTH**
**Office of Medical Cannabidiol**
**(Phone) 515-725-2076**
**(Fax) 515-725-0615**
**(E-mail) medical.cannabidiol@idph.iowa.gov**
**(Website) https://idph.iowa.gov/omc**

# MEDICAL CANNABIDIOL REGISTRATION CARD – ADULT PATIENT APPLICATION

For adult patients with a designated primary caregiver, the caregiver must also complete the Primary Caregiver Application. For patients under 18 years old (minors), use the Primary Caregiver Application, and do not complete this Adult Patient Application.

We now accept electronic applications! For online submission of registration applications, go to https://idph.iowa.gov/omc. Online submission is preferred and may result in quicker review and approval.

Print clearly. Incomplete applications may be denied. Application fees are non-returnable.

## PATIENT INFORMATION

1. Full Name:_____ _____ _____
First Middle Last

2. Gender ☐ Male ☐ Female ☐ Other

3. Date of Birth (must be 18 or older) _____/_____/_____

4. Driver's License Number or Iowa Nonoperator's Identification Card Number:_____

5. Phone:_____ ☐ Check this box if a confidential message may be left at this number.

6. E-mail Address (our preferred contact method, please print legibly):_____

7. Address Where You Live: _____
house number, street, unit # (if any)

_____
City State Zip

8. Mailing Address #(if different):_____
P.O. Box, apt. #

_____
City State Zip

## PATIENT ATTESTATION STATEMENT

**PATIENT 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 medical 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 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, §124E and the associated administrative rules, Iowa administrative code 641—154.

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 agree to notify the Office of Medical Cannabidiol, in writing, within 10 days of any change to the information provided.

Once applications are processed, communication will be sent to your residence or email address (if provided) with further instructions. **Please provide an email address for communication and program updates.**

**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.

**Patient Signature(required):**_____ _____/_____/_____
Date of Signature

**Legal Guardian/Power of Attorney Signature(if any):**_____ _____/_____/_____
Date of Signature

**Legal Guardian/Power of Attorney Name(if any):**_____ _____/_____/_____
Date of Signature

**Legal Guardian/Power of Attorney Phone(if any):**_____

## Adult Patient Application Checklist (for reference only)

**1. Patient Information and Attestation Section**

- Patient must sign and date all areas of this application in the Patient Attestation Section.

**2. Health Care Practitioner Certification Included**

- Patient's health care practitioner has completed the Health Care Practitioner form and certified that the patient has one or more of the qualifying debilitating medical conditions.

**3. Applicant - Patient - Documentation**

- A clear copy of the patient's valid photo identification card must be attached.
    - This must be: a valid Iowa Driver's License or a valid Iowa Nonoperator's Identification Card
    - If the Iowa resident patient does not have an Iowa issued ID, contact the office for further instructions

**4. APPLICATION FEE**

- Fee (A check or money order should be made out to "Iowa Department of Public Health." Cash will also be accepted.)
    - Regular Application Fee - $100
    - Reduced Application Fee - $25 The patient must provide ONE of the following items listed below as proof for reduced fee. (documentation must be current within the past 12 months)
    - Social Security Disability Benefit Recipient (provide copy of current benefit notice)
    - Supplemental Security Income Payment Recipient (provide a copy of current receipt)
    - Iowa Medicaid (provide a copy of the member card)

**To submit a paper application, mail the completed application and required materials to:**

Iowa Department of Public Health

ATTN: OMC

321 E. 12th Street

Des Moines, IA 50319-0075

**If the adult patient needs to have a caregiver with responsibility for managing his or her well-being in relation to the use of medical cannabidiol, or to assist with the transportation and handling of the medical cannabidiol, a separate Primary Caregiver application must be completed.**