IOWA DEPARTMENT OF PUBLIC HEALTH
Office of Medical Cannabidiol
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(Website) https://idph.iowa.gov/omc

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/omc. Online submission is preferred and may result in quicker review.

"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.

A. PRIMARY CAREGIVER 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

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 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.

Caregiver Signature(required):_____ _____/_____/_____
Date of Signature

B. ADULT PATIENT INFORMATION (required for adult patient only)

1. Full Name:_____ _____ _____
First Middle Last

2. Gender: ☐ Male ☐ Female ☐ Other

3. Date of Birth (Must be 18 or Older): _____/_____/_____

C. MINOR PATIENT INFORMATION (required for minor patient only)

1. Full Name:_____ _____ _____

First Middle Last

2. Gender: ☐ Male ☐ Female ☐ Other

3. Date of Birth: _____/_____/_____

4. Address Where Minor Lives: _____

house number, street, unit # (if any)

_____

City State Zip

5. Mailing Address:_____

P.O. Box, Apt. #

D. PATIENT'S PARENT OR LEGAL GUARDIAN INFORMATION (required for minor patient only)

1. Full Name:_____ _____ _____

First Middle Last

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

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

4. Primary Caregiver Signature:_____ _____/_____/_____

Date of Signature

The name of the minor patient's Parent or Legal Guardian will be printed on the back of the primary caregiver card. For confidentiality of the minor patient, their name is not printed on the card.

Primary Caregiver Application Checklist (for reference only)

1. Primary Caregiver Information and Attestation Section

- Primary caregiver must sign and date all areas of this application in the Primary Caregiver Attestation Section.

2. Patient Information Section

- If Adult Patient: The Adult Patient Information section must be completed
- If Minor Patient: The Minor Patient Information section must be completed

3. Health Care Practitioner Certification Included

- The patient's health care practitioner must complete the Health Care Practitioner Certification and certify that the patient has one or more of the qualifying debilitating medical conditions.

4. Applicant - Patient - Documentation

- For Iowa resident applicants: A clear copy of the primary caregiver applicant's valid photo identification card is attached.
- This must be: a valid Iowa driver's License or a valid Iowa Nonoperator'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 or a valid state-issued driver's license or nonoperator's identification card issued by a state bordering Iowa (NE, MO, IL, WI, MN, SD)
- 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.)

5. Application Fee

- Fee (A check or money order should be made out to "Iowa Department of Public Health." Cash will also be accepted.)
    - Primary Caregiver Application Fee - $25

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 patient is an adult, they must also submit a completed Health Care Practitioner form and an Adult Patient Application.