IOWA DEPARTMENT OF PUBLIC HEALTH

Office of Medical Cannabidiol

For the most current information regarding this application, medical cannabidiol laws in the state of Iowa and more, see the official website: https://idph.iowa.gov/mcarcp

MEDICAL CANNABIDIOL REGISTRATION CARD – PRIMARY CAREGIVER APPLICATION

Mail completed application and required materials to: **Iowa Department of Public Health** **ATTN: OMC** **321 E. 12th Street** **Des Moines, IA 50319-0075**	☐ New Caregiver Have you ever applied for a Medical Cannabidiol Registration Card in Iowa?	☐ Renewing Caregiver ☐ Yes – same patient ☐ Yes – different patient ☐ No
Print clearly. Incomplete applications may be denied. Application fees are non-returnable.		

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.

Name (First, Middle Initial, Last)		
Sex Designation ☐ Male ☐ Female	**Date of Birth** (Must be 18 or Older)	**Age**

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	☐ Check this box if a confidential message may be left at this number.
Secondary Phone Number	☐ Check this box if a confidential message may be left at this number.

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

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**

-- Next Section --

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		
Applicant Signature		**Date of Signature**

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HEALTH CARE PRACTITIONER CERTIFICATION

PRIMARY CAREGIVER APPLICANT INSTRUCTIONS: Have the patient's physician complete this entire section. This section should be submitted with your completed application to the Office of Medical Cannabidiol – partial applications will not be accepted. The application must be received by the Office of Medical Cannabidiol within **60 days** of the physician's signature date. Faxed and electronic copies will not be accepted.

NOTE: THIS DOES NOT CONSTITUTE A PRESCIPTION FOR CANNIBIDIOL or MEDICAL MARIJUANA.

HEALTH CARE PRACTITIONER INSTRUCTIONS: Print clearly. Answer all of the questions with information in the patient's medical record.

Patient's Name (First, Middle Initial, Last)	

HEALTH CARE PRACTITIONER INFORMATION

HEALTH CARE PRACTITIONER (means an individual licensed under Chapter 148 to practice medicine and surgery or osteopathic medicine and surgery who is a patient's primary care provider. "Health Care Practitioner" shall not include a physician assistant licensed under Chapter 148C or an advanced registered nurse practitioner licensed pursuant to Chapter 152 or 152E.

Physician Name (First, Middle Initial, Last, Suffix)		
Medical License Number	**License State** (Must be licensed in Iowa)	**License Type** (Must be DO or MD)
Practice Address (Street)		
Practice Address (P.O. Box, Suite #)		
Address (City, State ZIP Code)		
Phone Number	**Fax Number**	
Medical Specialty (Oncology, Neurology, Pain Management, etc.)		

PATIENT'S QUALIFYING DEBILITATING MEDICAL CONDITION

INSTRUCTIONS: Please mark the debilitating medical conditions which qualify the patient for a Medical Cannabidiol Registration Card.

☐	Cancer with severe or chronic pain
☐	Cancer with nausea or severe vomiting
☐	Cancer with cachexia or severe wasting
☐	Multiple sclerosis with severe and persistent muscle spasms
☐	Seizures, including those characteristic of epilepsy
☐	AIDS or HIV as defined in Iowa Code, section 141A.1
☐	Crohn's disease
☐	Amyotrophic lateral sclerosis
☐	Any terminal illness with a probable life expectancy of under one year and severe or chronic pain
☐	Any terminal illness with a probable life expectancy of under one year and nausea or severe vomiting
☐	Any terminal illness with a probable life expectancy of under one year and cachexia or severe wasting
☐	Parkinson's disease
☐	Untreatable Pain (*means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.*)

Patient's Name (First, Middle Initial, Last)	
HEALTH CARE PRACTITIONER CERTIFICATION	
INSTRUCTIONS: Please initial all sections. All sections must be initialed in order for the application to be approved.	
I have established a patient-provider relationship with the patient identified above.	________ Initials
I am a primary care provider involved in the diagnosis and treatment of this patient's debilitating medical condition.	________ Initials
I have determined in my medical judgement that this patient whom I have examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol under Iowa Code, chapter 124E.	________ Initials
I have provided this patient or the patient's parent or legal guardian with the explanatory information provided by the Iowa Department of Public Health (found on the Department's website at this web address: https://idph.iowa.gov/Medical-Cannabidiol-Act-Registration-Card-Program/Medical-Cannabidiol-Education-Material) on the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.	________ Initials
I agree to determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.	________ Initials
I agree to otherwise comply with all requirements established by the Iowa Department of Public Health pursuant to rule, and provide other information as requested.	________ Initials
I understand that I may provide, but have no duty to provide, this written certification of debilitating medical condition for the primary caregiver applicant or patient.	________ Initials

HEALTH CARE PRACTITIONER ATTESTATION	
I designate the person named in the Primary Caregiver Section as a Primary Caregiver in relation to the patient to manage the patient's well-being with respect to the use of medical cannabidiol pursuant to the provisions of Iowa Code, chapter 124E. I certify under penalty of perjury that the foregoing statements and all information provided by me on this application are true and correct. I understand the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand this application does not, by itself, provide authorization for the Medical Cannabidiol Registration Card for the above named patient/and/or caregiver(s).**	
Health Care Practitioner 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 SECTION			
☐	The patient's health care practitioner has completed the HEALTH CARE PRACTITIONER SECTION and certified that the patient has one or more of the qualifying debilitating medical conditions.		
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 nonoperator'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.)		
☐	A clear copy of one of the following items showing the primary caregiver applicant's name and permanent Iowa address is attached.		
☐	A valid Iowa driver's license	☐	A utility bill
☐	A valid Iowa non-operator's identification card	☐	A valid Iowa voter registration card
☐	A current Iowa vehicle registration certificate	☐	A statement from a financial institution
☐	A residential lease agreement	☐	A check or pay stub from an employer
☐	Valid documentation establishing a filing of homestead or military tax exemption on property located in Iowa		
☐	Another valid item with documentation showing established residency as approved by the Iowa Department of Public Health (Call 515-281-5616 to discuss other valid items.)		
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.)			