



Illinois Medical Cannabis Pilot Program Application for Registry Identification Card Persons Diagnosed with Terminal Illness Valid for Six (6) Months Only

Social Security Number (###-##-####)	Driver's License Number			Driver's License State		No Driver's License	
First Name	Middle Name			Last Name	t Name		
Home Address				Apartment or Suite Number			Number
City		County	County		State IL	ZIP Code	
Telephone Number (###-####)		E-mail Addre	E-mail Address				
Date of Birth (mm/dd/yyyy)		G	Gender Male Female				
Are you an active duty law enforcement officer, correctional officer correctional probation officer or firefighter? Yes No			Do you have a school bus permit or a Commercial Driver's License?				
00							
PHOTOGRAPH OF QUALIFYIN (No photograph is required for patier Attach a current digital passport-sized p	its under age ficture here (use	18 who are di e tape on the b	agnosed back of th		inal illness	;)	
PHOTO QUALIFYING PATIENT (Persons Age 18 and Over) Attach, using tape on the back only, a color photograph taken within	 Photograph Requirements Taken in the last 6 months Taken against a plain, white, or off-white background or backdrop In natural color (Do not use a filter) Full-face view directly facing the camera with a neutral facial expression and both eyes open At least 2 inches by 2 inches in size It is recommended you use a passport photo vendor to ensure the photograph meets these requirements. Contact the Division of Medical Cannabis if a photograph is in violation of or contradictory to the qualifying patient's religious convictions. 						
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the last 6 months		ictory to the q	ualifying p	oatient's rel	igious conv	rictions.	
		ictory to the q	ualifying p	oatient's rel	igious conv	rictions.	

FIRM OR ORGANIZATION NAME

PHONE NUMBER





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CERTIFICATIONS

I certify the information provided in this application is true and accurate to the best of my knowledge.

Submission of false, misleading or inaccurate information in connection with this application is grounds for revocation of my Illinois Medical Cannabis Qualifying Patient Registry Identification Card and other administrative, civil or criminal penalties.

I understand this application and the associated registry identification card, if approved, are only valid for six months from the date issued and if I no longer have a diagnosis of terminal illness after six months, I shall submit a full application, on the appropriate forms, along with all associated fees for a registry application card.

I additionally certify that I have been given actual Notice and understand that, notwithstanding the Compassionate Use of Medical Cannabis Pilot Program Act (Act):

- (i) cannabis is a prohibited Schedule I controlled substance under federal law;
- (ii) participation in the program is permitted only to the extent provided by the strict requirements of the Act;
- (iii) any activity not sanctioned by the Act may be a violation of state or federal law and could result in arrest, conviction, or incarceration:
- (iv) growing, distributing, or possessing cannabis under the Act, unless done through a federally-approved research program, is a violation of federal law:
- (v) growing, distributing, or possessing cannabis in any capacity, except through a federally-approved research program, may be a violation of state or federal law and could result in arrest, conviction or incarceration;
- use of medical cannabis, or possessing a medical cannabis patient or caregiver registry card, may affect an individual's ability to receive or retain federal or state licensure in other areas;
- (vii) use of medical cannabis or possessing a medical cannabis patient or caregiver registry card, in tandem with other conduct, may be a violation of state or federal law and could result in arrest, conviction or incarceration;
- (viii) participation in the Medical Cannabis Pilot Program does not authorize any person to violate federal law or state law;
- (ix) the Act does not provide any immunity from or affirmative defense to arrest or prosecution under federal law or state law, other than as set out in 410 ILCS 130/25; and
- (x) applicants shall indemnify, hold harmless, and defend the state of Illinois for any and all civil or criminal penalties resulting from participation in the program.

SIGNATURE OF QUALIFYING PATIENT	DATE (mm/dd/yyyy)
MEDICAL CANNABIS DISPENSARY SELECTION	
Name and Address of Dispensary	
Dispensary District	

You must select a dispensary to enter and purchase medical cannabis. The list of dispensaries currently licensed by the state of Illinois may be viewed at http://www.idfpr.com/Forms/MC/ListofLicensedDispensaries.pdf.





Illinois Medical Cannabis Pilot Program

Physician Confirmation of Diagnosis of Terminal Illness *** This section to be completed by the Qualifying Patient's physician ***

Do Not Complete for Veterans Receiving Medical Care at a VA Facility

PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

	LOGICITAL REGU	LAIION				
First N	ame		Middle Name		Last Name	
Office	Address (Location whe	ere the Qualifyi	ng Patient's Medical E	xamination was conduc	ted)	
Suite #	<i>‡</i>	City			State IL	ZIP Code
Office	Telephone Number (##	!#-###-####)	E-mail Address			
Illinois Physician License Number		Illinois Controlled Substances License Number				
Length of time patient has been under your care (years/months)		Date of in-person medical examination relating to this certification (mm/dd/yyyy)				
ATTE	STATIONS					
I				(the physician)	, have made a	diagnosis of terminal illness of
				(insert nam	e of disease or	illness) with a life expectancy
	6) months or fewer for t certify the following:	he qualifying p	atient			, and by my signature
1.	under my care, either	r for his/her pri	mary care or for his/he	r terminal illness, as spe	ecified on this f	The qualifying patient is orm. This bona-fide physician-l cannabis or a consultation
2.						llendar days. I understand the med for this qualifying patient's
3.	treating physicians fro	om the previou		tablished a medical reco		nedical records from other ifying patient related to the
I				(tl	he physician), h	nereby certify I am a physician
duly lice my mar correct.	nagement for the termin	cine in the state nal illness and/	e of Illinois. The qualify or their primary care. I	ving patient has the term attest the information p	ninal illness spe rovided in this	nereby certify I am a physician ecified, and the patient is under written certification is true and
Dhysis	an aignatura (na atau-	an annutud'	Cian in blue integrate		Doto of size	anturo (mm/dd/nnn)
Physician signature (no stamps accepted) – Sign in blue ink only				Date of sign	nature (mm/dd/yyyy)	





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DESIGNATED CAREGIVER INFORMATION

Social Security Number (###-##-###)	Driver's License Number		Driver's License State			No Driver's License	
First Name	Middle Name			Last Name			
Home Address			Apartment or Suite Number				
City		County				State	ZIP Code
						IL	
Telephone Number (###-####) E-mail A		E-mail Add	mail Address (required for online applicants)				
Date of Birth (mm/dd/yyyy)			Gender				
			☐ Male	Fem	ale		

If this application is for a person under age 18 who has been diagnosed with a terminal illness, a second designated caregiver can be added by making a copy of pages 4 and 5 and completing the requested information for the second designated caregiver.

DESIGNATED CAREGIVER PHOTOGRAPH

Attach a current digital passport-sized picture here (use tape on the back of the picture)

PHOTO DESIGNATED CAREGIVER

Attach, using tape on the back only, a color photograph taken within the last 6 months

Photograph Requirements

- Taken in the last 6 months
- · Taken against a plain, white, or off-white background or backdrop
- · In natural color (Do not use a filter)
- Full-face view directly facing the camera with a neutral facial expression and both eyes open
- · At least 2 inches by 2 inches in size

It is recommended you use a passport photo vendor to ensure the photograph meets these requirements.

Contact the Division of Medical Cannabis if a photograph is in violation of or contradictory to the qualifying patient's religious convictions.





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DESIGNATED CAREGIVER ATTESTATIONS

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- (ix) the Act does not provide any immunity from or affirmative defense to arrest or prosecution under federal law or state law, other than as set out in 410 ILCS 130/25; and
- (x) applicants shall indemnify, hold harmless, and defend the state of Illinois for any and all civil or criminal penalties resulting from participation in the program.

SIGNATURE OF DESIGNATED CAREGIVER	DATE (mm/dd/yyyy)

Mail the application and required documents to:

Illinois Department of Public Health Division of Medical Cannabis 535 West Jefferson Street Springfield, Illinois 62761-0001

Questions? Contact the Division of Medical Cannabis at 855-636-3688 or DPH.MedicalCannabis@Illinois.gov.





Illinois Medical Cannabis Pilot Program Application for Registry Identification Card Veterans Receiving Medical Services at a VA Facility

*** DO NOT COMPLETE THIS FORM IF YOU ARE NOT A VETERAN ***

Veterans receiving health care at a VA facility do not need to provide the physician written certification on page 3, but must instead provide the following information:

provide the following information:	
☐ Medical records from the VA facility for the last 12 mont	hs.
Copy of your DD-214 showing dates of service and cha	racter of service (type of discharge)
ATTESTATION OF TERMINAL ILLNESS	
I	hereby certify that I receive medical services from a VA facility
	(insert name of Under penalties including, but not limited to, perjury, and administrative g documents submitted by me in connection therewith, and all statements correct, and complete.
Signature (no stamps accepted) – Sign in blue ink only	Date of signature (mm/dd/yyyy)
State of Illinois	
County of	
Signed (or subscribed or attested) before me on	(date)
by(r	name of person).
(seal)	
Signature of Notary Public	