State of Illinois
Illinois Department of Public Health

TI

Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card for Persons Diagnosed with Terminal Illness Instructions

Persons who have been diagnosed with a terminal illness with a life expectancy of six (6) months or *less may apply for a medical cannabis registry identification card. The registry identification card will be valid for six (6) months only.* There is no application fee.

Qualifying patients must:

- Be a resident of the State of Illinois at the time of application and remain a resident during participation in the program
- Have been diagnosed with a terminal illness with a life expectancy of six (6) months or less
- Submit a complete application
- Make sure your physician completes and signs the physician confirmation of diagnosis of terminal illness. This form must be signed in blue ink. The in-person physical examination must take place within 90 days of the application submission date.
- Not hold a school bus permit or Commercial Driver's License
- Not be an active duty law enforcement officer, correctional officer, correctional probation officer, or firefighter.

The application must include:

❑	**Proof of Age, Identity and Residency** Submit a clear, color copy of your Illinois Driver's License, Illinois Temporary Visitor's Driver's License, US Military ID, or Illinois State ID (Minors - include a copy of your birth certificate)
❑	**Photo** Submit a photo taken within the last 6 months (using a passport photo vendor is recommended)

Note: If the address on your state-issued ID does not match the address on your application, you must submit a second document which shows your address.

Veterans receiving care at a U.S. Department of Veterans Affairs (VA) Facility:

- Submit a copy of your DD-214 showing dates of service and character of service (type of discharge)
- Provide a copy of your medical records from the VA facility for the last 12 months.
  - Use VA form 10-5345 to request these records (U.S. Department of Veterans Affairs, Request for and Authorization to Release Medical Records and Health Information). If you have received care for your debilitating medical condition for more than 5 years at a VA facility, you must mark "OTHER" on VA Form 10-5345 under "Information Requested" then write that you are requesting information about the treatment of your qualified condition for the most recent 12-month period. Under "PURPOSE(S) OR NEED FOR WHICH THE INFORMATION TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED" write "Personal Medical Purposes". Under "NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED" write your address. The records will be sent to you.
  - To obtain VA medical records electronically, go online to https://www.myhealth.va.gov/index.html
- Veterans receiving health care at a VA facility do not need to have a physician complete the Physician Confirmation of Diagnosis of Terminal Illness, but must instead complete the Attestation of Terminal Illness on page 6 of the application package. This form must be notarized.

Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card for Persons Diagnosed with Terminal Illness Instructions (continued)

Selecting a Designated Caregiver:

- The designated caregiver must be selected at the time of application and submit a photo, proof of age, identity and residency.
- Persons under age 18 who are diagnosed with a terminal illness may select a second caregiver by making a copy of pages 4 and 5 of the application and completing the requested information for the second designated caregiver.

Mail the application and the required documents to:

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

State of Illinois
Illinois Department of Public Health

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Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card

Persons Diagnosed with Terminal Illness

Valid for Six (6) Months Only

QUALIFYING PATIENT 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 IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address		
Date of Birth (mm/dd/yyyy)	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? ❑ Yes ❑ No		

PHOTOGRAPH OF QUALIFYING PATIENT OVER AGE 18

(No photograph is required for patients under age 18 who are diagnosed with terminal illness)

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

PHOTO
QUALIFYING PATIENT
(Persons Age 18 and Over)

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.

This application was prepared by:

PRINT/TYPE PREPARER'S NAME _____ DATE (mm/dd/yyyy) _____

FIRM OR ORGANIZATION NAME _____ PHONE NUMBER _____

Printed by Authority of the State of Illinois
P.O.#3117018 5M 7/16

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State of Illinois
Illinois Department of Public Health

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Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card

Persons Diagnosed with Terminal Illness

Valid for Six (6) Months Only

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;

(vi) 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.

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Illinois Department of Public Health

Illinois Medical Cannabis Pilot Program

TI 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

First Name	Middle Name	Last Name	
Office Address (Location where the Qualifying Patient's Medical Examination was conducted)			
Suite #	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)		

ATTESTATIONS

I _____ (the physician), have made a diagnosis of terminal illness of _____ (insert name of disease or illness) with a life expectancy of six (6) months or fewer for the qualifying patient _____, and by my signature below certify the following:

1. I have established a bona-fide physician-patient relationship with the qualifying patient applicant. The qualifying patient is under my care, either for his/her primary care or for his/her terminal illness, as specified on this form. This bona-fide physician-patient relationship is not limited to the diagnosis of terminal illness for the patient to use medical cannabis or a consultation simply for that purpose.
2. I have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I understand the Illinois Department of Public Health may request additional confirmation of the assessment(s) performed for this qualifying patient's terminal illness.
3. I have completed an assessment of the qualifying patient's medical history, including the review of medical records from other treating physicians from the previous 12 months. I have established a medical record for the qualifying patient related to the patient's terminal illness and continued treatment under my care.

I _____ (the physician), hereby certify I am a physician duly licensed to practice medicine in the state of Illinois. The qualifying patient has the terminal illness specified, and the patient is under my management for the terminal illness and/or their primary care. I attest the information provided in this written certification is true and correct.

_____ _____

Physician signature (no stamps accepted) – Sign in blue ink only | Date of signature (mm/dd/yyyy)

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Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card

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Valid for Six (6) Months Only

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 IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address (required for online applicants)		
Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female		

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

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DESIGNATED CAREGIVER ATTESTATIONS

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 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;

(vi) 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 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.

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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:

- ❑ Medical records from the VA facility for the last 12 months.
- ❑ Copy of your DD-214 showing dates of service and character of service (type of discharge)

ATTESTATION OF TERMINAL ILLNESS

I _____ hereby certify that I receive medical services from a VA facility and have been diagnosed with a terminal illness of _____ (insert name of disease or illness) with a life expectancy of six (6) months or less. Under penalties including, but not limited to, perjury, and administrative action, I declare that I have examined the application, all supporting documents submitted by me in connection therewith, and all statements contained therein, and to the best of my knowledge, they are true, 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 _____ (name of person).

(seal)

_____

Signature of Notary Public

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