



Lori A. Weaver
Commissioner

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Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
THERAPEUTIC CANNABIS PROGRAM

29 HAZEN DRIVE, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
email: TCP@dhhs.nh.gov

GUARDIANSHIP PATIENT APPLICATION
For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

Information about the Therapeutic Cannabis Program, including the law ([RSA 126-X](#)), the rules ([He-C 400](#)), and all required forms, is available on the Program’s website at: <https://www.dhhs.nh.gov/tcp>

General Instructions for an Adult Patient with a Legal Guardian

- The “Guardianship Patient Application” is a combined application for both an adult patient and their Designated Caregiver.
- Use this “Guardianship Patient Application” if the legal guardian of the adult patient will be the Designated Caregiver.
- If the legal guardian will not be the patient’s Designated Caregiver, please use the “Patient Application.”
- This application must be completed by the adult patient’s legal guardian.
- An adult patient with court-appointed co-guardians may have two Designated Caregivers, both of whom must be court-appointed co-guardians for the patient.

Application Instructions

1. Read the “General Program Information” at the end of this application packet.
2. Complete ALL required information on pages 1-3. Complete pages 4-6 to provide voluntary demographic information.
3. **Submit with this Application Form:**
 - a. The “Written Certification for the Therapeutic Use of Cannabis” form completed by the patient’s medical provider.
 - b. Proof of New Hampshire residency.* Submit ONE of the following:
 - A copy of the patient’s New Hampshire driver’s license or New Hampshire State ID (front only); OR
 - Any other documentation that contains the patient’s name and current NH address, such as a current lease agreement or vehicle registration, or a utility bill, medical bill, property tax bill, mortgage statement, bank statement, government check, or payroll check with a date showing that it was issued within the previous 6 months; OR
 - Other state or federal government-issued identification that shows the patient’s name and NH address.

**If proof of residency is not available for the patient applicant, submit it for one of the Designated Caregiver applicants.*
**Proof of residency is not required for renewal applications if there has not been a change of address.*
 - c. A \$50 application fee:
 - A check or money order made payable to “Treasurer, State of New Hampshire” in the amount of \$50.
 - The Program cannot accept cash, credit cards, or installment payments.
 - d. Proof of guardianship for each Designated Caregiver applicant listed on this application:
 - Submit a copy of the entire order that shows the powers granted to the guardian, which must include powers related to healthcare decisions.
4. Mail or hand-deliver the following:

| Required Documents: | To This Address: |
|--|---|
| <input type="checkbox"/> A completed Guardianship Patient Application <input type="checkbox"/> A completed Written Certification (from the medical provider) <input type="checkbox"/> Proof of NH residency (see 3b above) <input type="checkbox"/> Application fee (see 3c above) <input type="checkbox"/> Proof of guardianship (see 3d above) | NH Department of Health and Human Services Therapeutic Cannabis Program 29 Hazen Drive Concord, NH 03301 |

APPLICATION INSTRUCTIONS (continued)

5. Application processing:

a. Application processing takes up to 3 weeks.

- The Program will approve or deny a complete application within 15 days of receipt.
- The Program will issue a Registry ID Card within 5 days of approval.

b. Incomplete applications:

- You will be notified in writing within 10 days of receipt if an application is incomplete.
- You will be asked to submit the missing information/documentation within 30 days from the date of the notice.
- If you don't provide the missing information/documentation within 6 months of the notice, your application will be closed. You will need to reapply by resubmitting ALL required application materials, including the fee.
- The processing times listed in 5a above will begin when the application is complete.

Notice Explaining Federal Law on the Possession of Cannabis (RSA 126-X:, VI)

RSA 126-X, Use of Cannabis for Therapeutic Purposes creates an exemption in state law from criminal penalties for the therapeutic use of cannabis provided that its use is in compliance with RSA 126-X. State law does not exempt a person from federal criminal penalties for the possession of cannabis.

Federal administrations have expressed intention not to pursue or target patients and their caregivers who possess or use small amounts of cannabis for therapeutic use who are part of and compliant with a well-regulated state therapeutic cannabis program. However, federal law does not allow for the medical or therapeutic use of cannabis, and the federal government can enforce federal cannabis laws anywhere in the United States, including in states that allow the therapeutic use of cannabis. Federal criminal penalties for the possession of cannabis, in any amount, range from misdemeanors to felonies, and may include incarceration and fines.

To decrease the risk of any federal law enforcement action, patients and caregivers should know and abide by New Hampshire law with regard to the possession and use of therapeutic cannabis at all times.

OTHER FEDERAL IMPLICATIONS

Qualifying patients who use cannabis may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm or ammunition, those related to federally subsidized housing, those related to immigration and naturalization, or the inability to pass a security clearance. (See below for more information on the federal firearms restriction.)

FEDERAL FIREARMS NOTICE

The U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) has directed federal firearms licensees, in an open letter issued in 2011, not to transfer firearms or ammunition to users of a controlled substance, including marijuana, regardless of whether their state has passed legislation authorizing marijuana use for medicinal purposes. According to the federal directive, any user of marijuana "is an unlawful user of or addicted to a controlled substance, and is prohibited by Federal law from possessing firearms or ammunition."

If a federal firearms licensee is aware that a person is in possession of a card authorizing the possession and use of marijuana under state law, that licensee has "reasonable cause to believe" that the person is an unlawful user of a controlled substance, and may not transfer firearms or ammunition to that person, even if the person answered "no" to question 21.g on "ATF Form 4473." Note that this form was revised effective December 2022 to include specific reference to state marijuana laws.

References

- ATF open letter: <https://www.atf.gov/file/60211/download>
- ATF Form 4473: <https://www.atf.gov/file/61446/download>
- HUD memos: <https://www.hud.gov/sites/documents/MED-MARIJUANA.PDF>
<https://www.hud.gov/sites/documents/USEOFMARIJINMFASSISTPROPTY.PDF>

GUARDIANSHIP PATIENT APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: This application is to be completed by the adult patient's legal guardian.

- Initial Application
- Renewal Application
(or expired/lapsed)

Note to Applicant: *These items are required to be submitted with this Application:*

1. A completed *Written Certification* (from the patient's medical provider)
 2. A \$50 application fee (check/money order, payable to "Treasurer – State of NH")
 3. *Proof of guardianship* (must include powers related to healthcare decisions)
 3. *Proof of NH residency** (copy of NH license/State ID, current lease, recent utility bill, etc.)
- *If not available for patient applicant, submit for the caregiver applicant*
**This is NOT required for renewals if you are at the same address*

Send to: NH DHHS, Therapeutic Cannabis Program, 29 Hazen Dr, Concord, NH 03301

PATIENT INFORMATION

| | | | |
|--------------------------------|--|----------------|---|
| Name | First | Last | Middle Initial |
| Date of Birth | MM/DD/YYYY | Gender: | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary/Other gender <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Choose to self-describe: _____ |
| Phone Number (optional) | | | |
| Mailing Address | Street/P.O. Box/Apt # | | |
| | City | State | Zip Code |
| Physical Address | (If different than mailing address) (If experiencing homelessness, this is not required) | | |

DESIGNATED CAREGIVER (GUARDIAN) INFORMATION

| | | | |
|--|---------------------------------|----------------|---|
| Name | First | Last | Middle Initial |
| Date of Birth | MM/DD/YYYY | Gender: | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary/Other gender <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Choose to self-describe: _____ |
| Phone Number | | | |
| Mailing Address <small>(if different than the patient)</small> | Street/P.O. Box/Apt # | | |
| | City | State | Zip Code |
| Physical Address | (If different than the patient) | | |

SECOND DESIGNATED CAREGIVER (GUARDIAN) INFORMATION – OPTIONAL

| | | | |
|--|---------------------------------|----------------|---|
| Name | First | Last | Middle Initial |
| Date of Birth | MM/DD/YYYY | Gender: | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary/Other gender <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Choose to self-describe: _____ |
| Phone Number | | | |
| Mailing Address <small>(if different than the patient)</small> | Street/P.O. Box/Apt # | | |
| | City | State | Zip Code |
| Physical Address | (If different than the patient) | | |

MEDICAL PROVIDER INFORMATION

Provide information about the medical provider who completed the Written Certification.

| | | |
|-------------------------|----------------|-------|
| Name | First | Last |
| Business Address | Street/Suite # | |
| | City | State |
| Phone Number | | |

MEDICAL INFORMATION RELEASE

I, hereby, authorize the release of relevant medical information by the provider listed above to the NH DHHS if additional information about the qualifying medical condition or Written Certification is required.

Legal Guardian Signature**Date**

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGMENTS

| |
|---|
| I understand that Registry ID Cards are valid for one year, unless a shorter or longer duration is indicated by the patient's medical provider. Cards must be renewed or extended prior to their expiration in order to prevent a lapse in registration. |
| I understand that if I am notified of a denial or a revocation I have 30 days to appeal the decision from the date of the notice, and that if an appeal request is not made within that timeframe then I will have waived my right to an appeal and the action of the Department shall become final. |
| I understand that I may not possess, between myself and my Qualifying Patient, more than two ounces of cannabis per Qualifying Patient, or obtain more than 2 ounces of cannabis in any 10-day period from any source per Qualifying Patient. |
| I understand that as a Designated Caregiver I am not permitted to use cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so. |
| I understand that my Qualifying Patient may only use cannabis for the purpose of treating or alleviating their qualifying medical condition. |
| I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X. |
| I understand that my Qualifying Patient may not be under the influence of cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in their place of employment, without the written permission of the employer; or (3) while operating heavy machinery or handling a dangerous instrumentality. |
| I understand that my Qualifying Patient may not smoke or vaporize cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field. |
| I understand that my Qualifying Patient and I may not be in possession of cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility. |
| I understand that my Qualifying Patient may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property. |
| I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Department of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV. |
| I understand that if my Qualifying Patient or I am found to be in possession of cannabis outside of our home and we are not in possession of a Registry ID Card, we may be subject to a fine of up to \$100. |
| I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined \$500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement official or for the use of cannabis other than use undertaken pursuant to this RSA 126-X. |
| I understand that the protections granted by RSA 126-X for the use of cannabis are applicable only within NH. |
| I understand that my Qualifying Patient and I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke a Registry ID Card for any violation of any provision of RSA 126-X or the rules adopted thereunder. |
| I understand that I, by possessing cannabis, and my Qualifying Patient, by using cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federally subsidized housing, those related to immigration and naturalization, or the inability to pass a security clearance. |

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Acknowledgments listed above.

I, hereby, attest that I have not been convicted of a felony offense in this or any other state, and I agree to notify the Department if I am convicted of a felony offense subsequent to being issued a Registry ID Card.

I, hereby, certify that the patient is a resident of New Hampshire and the facts as stated in this Application are accurate to the best of my knowledge and belief. I understand that any false statements made on this Application are punishable as unsworn falsification under RSA 641:3.

I, hereby, pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, acknowledge that diversion of cannabis shall result in revocation of my Registry ID Card, and acknowledge that the sale of cannabis to anyone who is not a qualifying patient or a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than \$300,000, or both, in addition to other penalties for the illegal sale of cannabis.

| | |
|--|-------------|
| Legal Guardian Signature | Date |
| Second Legal Guardian Signature (if applicable) | Date |

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

PATIENT INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- No
 Yes, specify (one or more categories may be selected):
 Mexican, Mexican American, Chicano/a Puerto Rican
 Another Hispanic, Latino/a, or Spanish origin Cuban

What is your race? (One or more categories may be selected)

- White Korean
 Black or African American Vietnamese
 American Indian or Alaska Native Other Asian
 Asian Indian Native Hawaiian
 Chinese Guamanian or Chamorro
 Filipino Samoan
 Japanese Other Pacific Islander

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

- No Yes

Employment

Are you currently: (Check all that apply)

- Employed full time (35 or more hours per week)
 Employed part time (up to 35 hours per week)
 Unemployed and currently looking for work
 Unemployed and not currently looking for work
 Student Retired Homemaker
 Self-employed Unable to work

What is your annual household income?

- Less than \$25,000 \$75,000 to \$99,999
 \$25,000 to \$49,999 \$100,000 or more
 \$50,000 to \$74,999

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

- No
 Yes, specify: (Check all that apply)
 Medicaid
 Supplemental Security Income (SSI)
 Social Security Disability Insurance (SSDI)
 Other, specify: _____

Education

What is the highest level of education completed?

- Some high school Community college/2-yr degree
 High school diploma / GED University/4-year college
 Technical school Graduate program or more

Are you currently enrolled in school?

- No
 Yes, specify:
 High school University / 4-year college
 Technical school Graduate program
 Community college/2-yr degree

Health Insurance

What is the primary source of your health care coverage?

- Employer-based plan (including through another person's employer)
 A plan that you or a family member buys on your own
 Medicare
 Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
 TRICARE, VA, or Military
 Other source
 None (no coverage)

Marital Status

What is your marital status?

- Married Separated
 Divorced Never married
 Widowed Member of an unmarried partnership

Language Proficiency

How well do you speak English?

- Very well Well Not well Not at all

Do you speak another language other than English at home?

- No
 Yes, Spanish
 Yes, not Spanish. Specify: _____

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

CAREGIVER INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- No
 Yes, specify (one or more categories may be selected):
 Mexican, Mexican American, Chicano/a Puerto Rican
 Another Hispanic, Latino/a, or Spanish origin Cuban

What is your race? (One or more categories may be selected)

- | | |
|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Pacific Islander |

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

- No Yes

Employment

Are you currently: (Check all that apply)

- Employed full time (35 or more hours per week)
 Employed part time (up to 35 hours per week)
 Unemployed and currently looking for work
 Unemployed and not currently looking for work
 Student Retired Homemaker
 Self-employed Unable to work

What is your annual household income?

- Less than \$25,000 \$75,000 to \$99,999
 \$25,000 to \$49,999 \$100,000 or more
 \$50,000 to \$74,999

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

- No
 Yes, specify: (Check all that apply)
 Medicaid
 Supplemental Security Income (SSI)
 Social Security Disability Insurance (SSDI)
 Other, specify: _____

Education

What is the highest level of education completed?

- | | |
|--|--|
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Community college/2-yr degree |
| <input type="checkbox"/> High school diploma / GED | <input type="checkbox"/> University/4-year college |
| <input type="checkbox"/> Technical school | <input type="checkbox"/> Graduate program or more |

Are you currently enrolled in school?

- No
 Yes, specify:
 High school University / 4-year college
 Technical school Graduate program
 Community college/2-yr degree

Health Insurance

What is the primary source of your health care coverage?

- Employer-based plan (including through another person's employer)
 A plan that you or a family member buys on your own
 Medicare
 Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
 TRICARE, VA, or Military
 Other source
 None (no coverage)

Marital Status

What is your marital status?

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Never married |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Member of an unmarried partnership |

Language Proficiency

How well do you speak English?

- Very well Well Not well Not at all

Do you speak another language other than English at home?

- No
 Yes, Spanish
 Yes, not Spanish. Specify: _____

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

SECOND CAREGIVER INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- No
 Yes, specify (one or more categories may be selected):
 Mexican, Mexican American, Chicano/a Puerto Rican
 Another Hispanic, Latino/a, or Spanish origin Cuban

What is your race? (One or more categories may be selected)

- White Korean
 Black or African American Vietnamese
 American Indian or Alaska Native Other Asian
 Asian Indian Native Hawaiian
 Chinese Guamanian or Chamorro
 Filipino Samoan
 Japanese Other Pacific Islander

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

- No Yes

Employment

Are you currently: (Check all that apply)

- Employed full time (35 or more hours per week)
 Employed part time (up to 35 hours per week)
 Unemployed and currently looking for work
 Unemployed and not currently looking for work
 Student Retired Homemaker
 Self-employed Unable to work

What is your annual household income?

- Less than \$25,000 \$75,000 to \$99,999
 \$25,000 to \$49,999 \$100,000 or more
 \$50,000 to \$74,999

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

- No
 Yes, specify: (Check all that apply)
 Medicaid
 Supplemental Security Income (SSI)
 Social Security Disability Insurance (SSDI)
 Other, specify: _____

Education

What is the highest level of education completed?

- Some high school Community college/2-yr degree
 High school diploma / GED University/4-year college
 Technical school Graduate program or more

Are you currently enrolled in school?

- No
 Yes, specify:
 High school University / 4-year college
 Technical school Graduate program
 Community college/2-yr degree

Health Insurance

What is the primary source of your health care coverage?

- Employer-based plan (including through another person's employer)
 A plan that you or a family member buys on your own
 Medicare
 Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
 TRICARE, VA, or Military
 Other source
 None (no coverage)

Marital Status

What is your marital status?

- Married Separated
 Divorced Never married
 Widowed Member of an unmarried partnership

Language Proficiency

How well do you speak English?

- Very well Well Not well Not at all

Do you speak another language other than English at home?

- No
 Yes, Spanish
 Yes, not Spanish. Specify: _____

THERAPEUTIC CANNABIS PROGRAM – GENERAL PROGRAM INFORMATION

(Please keep for your records)

Program Website: <https://www.dhhs.nh.gov/tcp>

Applications and Forms: <https://www.dhhs.nh.gov/tcp-forms>; (603) 271-9255

Contact: (603) 271-9333; TCP@dhhs.nh.gov; NH DHHS, Therapeutic Cannabis Program, 29 Hazen Dr., Concord, NH 03301

General Instructions/Requirements for Adult Patients with a Legal Guardian

- This “Guardianship Patient Application” is a combined application for both an adult patient and their legal guardian who will be the patient’s Designated Caregiver.
- Use this “Guardianship Patient Application” if the legal guardian of the adult patient will be the Designated Caregiver.
- If the legal guardian will not be the patient’s Designated Caregiver, please use the “Patient Application.”
- The patient must be a resident of New Hampshire.
- The patient must be diagnosed by a medical provider as having a qualifying medical condition that is listed in NH law.
- If using this application, the legal guardian:
 1. Must apply for and be approved as the patient’s Designated Caregiver
 2. Must be at least 21 years old
 3. Must never have been convicted of a felony
- If using this application, both the patient and the caregiver must be issued a Registry ID Card by the Program.
- An adult patient with court-appointed co-guardians may have two Designated Caregivers, both of whom must be court-appointed co-guardians for the patient.

Qualifying Medical Conditions

A medical provider must certify that the patient has a qualifying medical condition that is listed in NH law, as follows:

- Moderate to severe chronic pain; OR
- Severe pain; OR
- Moderate or severe post-traumatic stress disorder; OR
- Autism spectrum disorder (with an additional provider consultation requirement for those under age 21); OR
- Opioid use disorder with associated symptoms of cravings and/or withdrawal (requires a provider who is actively treating the patient for opioid use disorder and board-certified in Addiction Medicine or Addiction Psychiatry); OR
- Any combination of a qualifying diagnosis from (1) AND a qualifying symptom or side effect from (2):
 1. Cancer; glaucoma; positive status for human immunodeficiency virus; acquired immune deficiency syndrome; hepatitis C; amyotrophic lateral sclerosis; muscular dystrophy; Crohn’s disease; multiple sclerosis; chronic pancreatitis; spinal cord injury or disease; traumatic brain injury; epilepsy; lupus; Parkinson’s disease; Alzheimer’s disease; ulcerative colitis; Ehlers-Danlos syndrome; or one or more injuries or conditions that has resulted in one or more qualifying symptoms under (2); AND
 2. Elevated intraocular pressure; cachexia; chemotherapy-induced anorexia; wasting syndrome; agitation of Alzheimer’s disease; severe pain; constant or severe nausea; moderate to severe vomiting; seizures; or severe, persistent muscle spasms; or moderate to severe insomnia.

Medical Providers

ANY PHYSICIAN, PHYSICIAN ASSISTANT (PA), OR ADVANCED PRACTICE REGISTERED NURSE (APRN) WHO IS LICENSED IN NH IS *PERMITTED* BY LAW TO CERTIFY A PATIENT FOR THE THERAPEUTIC CANNABIS PROGRAM.

- Talk with any of your current medical providers about your interest in the Program. Ask if they will certify the patient by issuing a “Written Certification” (available on the Program’s website).
- State law does not *require* any medical provider to issue a Written Certification to their patients.
- There is no requirement for a provider to be registered with the State as a “marijuana doctor.”
- There is not a public list of medical providers who participate in the Program. The Program cannot refer you to a provider. You must work with your current providers or develop a relationship with a new provider to become certified.
- In addition, physicians and APRNs (but not PAs) licensed in Maine, Massachusetts, or Vermont are *permitted* to certify you. Border-state providers must be “primarily responsible for your care related to your qualifying medical condition,” which means that you should ask your primary care provider or your specialist who is treating your qualifying condition.

The certifying medical provider may:

- Issue a Written Certification for any duration up to 3 years. The default duration is one year.
- Send instructions to your Alternative Treatment Center (ATC; dispensary), such as the type of cannabis or the means by which the cannabis should be administered, and the ATC is required to follow such instructions.
- Withdraw the certification at any time and for any reason if in the provider’s opinion the patient should no longer be certified for the therapeutic use of cannabis.

GENERAL PROGRAM INFORMATION (Continued)

Alternative Treatment Centers

There are seven Alternative Treatment Center (ATC) dispensaries in NH for dispensing therapeutic cannabis. Registered Qualifying Patients and their Designated Caregivers are allowed to purchase cannabis from any ATC location in the state. You must show your Registry ID Card and valid photo identification to enter the ATC dispensaries. The ATCs in New Hampshire are as follows:

- **GraniteLeaf Cannabis** (formerly Prime ATC), with dispensaries located in **Merrimack** and **Chichester**.
380 Daniel Webster Highway, Units A and C, Merrimack, NH 03054. Phone: (603) 262-5035
349 Dover Road (Route 4), Chichester, NH 03258. Phone: (603) 212-1500
Website: graniteleaf.com. Email: info@graniteleaf.com.
- **Sanctuary ATC**, with dispensaries located in **Plymouth** and **Conway**.
568 Tenney Mountain Highway, Plymouth, NH 03264. Phone: (603) 346-4619
234 White Mountain Highway (Route 16), Conway, NH 03818. Phone: (603) 662-0113
Website: www.sanctuaryatc.org. Email: info@sanctuaryatc.org.
- **Temescal Wellness**, with dispensaries located in **Dover**, **Lebanon**, and **Keene**.
26 Crosby Road, Units 11-12, Dover, NH 03820
367 Route 120, Unit E-2, Lebanon, NH 03766
69 Island Street, Suite 1, Keene, NH 03431
Website: nh.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383

Confidentiality

The Program will maintain the confidentiality of all personal information about applicants, patients, caregivers, and certifying medical providers contained in the confidential Registry database. Local and state law enforcement officers, however, are allowed to receive limited information from the Registry if a person has been arrested or detained, or when there is probable cause to believe either cannabis is possessed at a specific address or by a specific individual.

Renewals/Extensions

- A Registry ID Card is effective for up to three years.
- There is no difference between the initial and the renewal application process or forms, except that:
 - Proof of NH residency is not required if there has not been a change of address (unless your card has been expired for more than 6 months).
- There is no penalty for renewing after the suggested deadline; however, please submit your renewal materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.
- A card with a duration that is shorter than three years may be extended by using the "Written Certification Extension" form, located on the Program's website: <https://www.dhhs.nh.gov/tcp-forms>