STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

THERAPEUTIC CANNABIS PROGRAM

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Application for the Therapeutic Use of Cannabis
Qualifying Patient

GENERAL PROGRAM INFORMATION

Information about the Therapeutic Cannabis Program, including the enabling law (RSA 126-X), the administrative rules (He-C 400), and all required forms, is available on the Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

Application process

The application process takes up to 20 calendar days from the date a complete application is received by the Therapeutic Cannabis Program. The Program will approve or deny an application within 15 calendar days of receiving a complete application. If approved, the Program will issue a Registry Identification Card within 5 days of approval. *Information regarding application status will not be given over the phone.*

Incomplete application

If an application is received and it does not contain all required information and supporting documentation, it will be considered incomplete. The Program will notify you in writing within 10 business days of receiving an incomplete application. The notice will specify the information or documentation required to be submitted before the application can be processed. If you fail to provide the missing information or documentation within 30 days of the notice, your application shall be determined to be incomplete and will not be processed.

Application fees

The $50 application fee is non-refundable. Make check or money order payable to "Treasurer, State of New Hampshire." Fees will not be returned to an applicant whose application is denied or determined to be incomplete.

Requirements for applicants who are under 18 years of age

- The application must be completed by the applicant's custodial parent or legal guardian on behalf of the applicant.
- The applicant's custodial parent or legal guardian must be approved by the Program as the applicant's Designated Caregiver. An application for a minor patient will not be approved unless the applicant's custodial parent or legal guardian has been approved as a Designated Caregiver.
- The application must include two "Written Certification for the Therapeutic Use of Cannabis" forms, completed by two separate health care providers. One of the health care providers must be a pediatrician, and both of the providers must have a provider-patient relationship of at least 3 months duration with the minor; unless the onset or diagnosis of the qualifying condition occurred within the past 3 months and the certifying provider is primarily responsible for the care related to this condition.
- If parents share legal custody (joint decision-making responsibility) of a minor applicant, the parent submitting the application shall provide the other parent with copies of the completed application and the completed Written Certifications prior to submitting the application to the Program.
- In cases where a minor applicant's legal guardian is not a custodial parent, the legal guardian shall submit proof of legal guardianship with the application.

Designated Caregivers

You may designate a caregiver either on the initial application or any time after you have been approved as a Qualifying Patient. You may designate only one caregiver at a time. The person you designate must submit an "Application for the Therapeutic Use of Cannabis – Designated Caregiver," be approved by the Program, and be issued a Registry Identification Card before the person can assist you with your therapeutic use of cannabis. A Designated Caregiver must be at least 21 years old and must have never been convicted of a felony. The Program will notify you if the person you designate as your caregiver is approved or denied. Please note that your Designated Caregiver may receive compensation for actual costs, such as gas, tolls, etc., but not for the time or labor, associated with assisting you with your therapeutic use of cannabis.

You may use the "Caregiver Designation/Removal" form, available on the Program's website, to designate a caregiver after you've submitted your initial application or if you want to change your current Designated Caregiver.

Alternative Treatment Centers

On your initial application you will be required to select an Alternative Treatment Center (ATC). You will only be allowed to purchase cannabis from the ATC you have selected. You may change your ATC at any time by completing a "Change of Information/Lost Card" form and submitting it to the Program. A change in the designation of your ATC may take up to 10 days. The ATCs are as follows:

- Prime Alternative Treatment Centers of NH, Inc., with a dispensary located in Merrimack.
  380 Daniel Webster Highway, Merrimack, NH 03054
  Website: www.primeatc.com. Email: info@primeatc.com. Phone: (888) 298-7746
- Sanctuary ATC, with a dispensary located in Plymouth.
  568 Tenney Mountain Highway, Plymouth, NH 03264
  Website: www.sanctuaryatc.org. Email: info@sanctuaryatc.org. Phone: (603) 346-4619
- Temescal Wellness, Inc., with dispensaries located in Dover and Lebanon.
  367 Route 120, Unit E-2, Lebanon, NH 03766
  26 Crosby Road, Units 11-12, Dover, NH, 03820
  Website: www.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383
  Note: The Dover and Lebanon dispensaries are separate ATCs. Selecting one does not allow a Qualifying Patient or Designated Caregiver to utilize the other location.

Changes of information

You are required to notify the Program in writing of changes to the following:

- *Name or Address.* Use the "Change of Information/ Lost Card" form to request such a change, which is available on the Program's website. A new Registry Identification Card, including a new identification number, will be issued to you within 20 days of your request. There is a $25 fee for the replacement card. Failure to notify the Program of a change to your name or address within 10 days of the change will result in a fine of $150.
- *Alternative Treatment Center.* Use the "Change of Information/ Lost Card" form to request such a change. There is no fee to change your ATC, and you will not be issued a new Registry Identification Card. (See "Alternative Treatment Centers" above.)
- *Designated Caregiver.* Use the "Caregiver Designation/Removal" form to request such a change, which is available on the Program's website. There is no fee associated with this change, and you will not be issued a new Registry Identification Card. (See "Designated Caregivers" below.)

Return of outdated or expired Registry Identification Card

A Registry Identification Card with outdated information, whether due to a change of information or because it has expired, must be returned to the Program within 10 business days of your receipt of a new card. Failure to timely return the outdated card to the Program shall be grounds for the Program to void the newly issued card until the outdated card is returned to the Program. You will not be able to purchase cannabis at an ATC with a voided Registry Identification Card.

Lost Registry Identification Card

If you lose your Registry Identification Card, whether due to loss, theft, or destruction, you are required to notify the Program in writing within 10 days of discovering the loss. Please submit the "Change of Information/Lost Card" form along with a check or money order made payable to "Treasurer, State of New Hampshire" in the amount of $25. Within 5 calendar days of receiving written notice of the loss and the $25 fee, the Program will re-issue a new Registry Identification Card, including a new identification number. You will not be able to purchase cannabis at an ATC without a valid Registry Identification Card.

THERAPEUTIC CANNABIS PROGRAM
QUALIFYING PATIENT APPLICATION INSTRUCTIONS

1. Carefully read the general program information available on the Program's website.
2. Type or print in ink your responses on the application.
3. All releases, certifications, and acknowledgments on the application that require signature or initialing must be completed in ink. Photocopies or facsimiles of the application will not be accepted.
4. Have your health care provider complete the "Written Certification for the Therapeutic Use of Cannabis" form. The Written Certification form must be completed and signed by an individual who:
   a. Is a physician or an advanced practice registered nurse (APRN);
   b. Has an active license in good standing from the NH Board of Medicine or the NH Board of Nursing;
   c. Has an active registration from the US Drug Enforcement Agency to prescribe controlled substances; and
   d. Has a provider-patient relationship with you of at least 3 months duration, unless the onset or diagnosis of your qualifying condition occurred within the past 3 months and the certifying provider is primarily responsible for the care related to this condition.
5. Have your health care provider return the Written Certification form to you when it is completed. Do not have your health care provider return the Written Certification form to the Program. Note that for applicants who are minors, two separate Written Certification forms, completed by two different health care providers, one of whom must be a pediatrician, are required to be submitted. Make sure you submit your application within 60 days of the date of the Written Certification(s); otherwise your application will be considered incomplete.
6. Arrange to have a digital photograph of your face taken. The digital photograph will be used for your Registry Identification Card. A passport photo taken by a studio or store is preferred, but you may also use your own digital camera. In either case, the photograph you submit must meet all of the following requirements:
   a. The digital photograph must be in .jpg format, and supplied on a compact disc (CD) that has is labeled with your name and date of birth;
   b. The photograph shall contain a front image of your full face, taken in natural color;
   c. Your face must appear against a white background;
   d. Your face takes up at least 70% of the photograph;
   e. Do not wear a hat, sunglasses, or any item that alters or disguises the overall features of your face; and
   f. The photograph must be taken not more than 30 days prior to the date of the application.
7. Enclose 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. All application fees are non-refundable in accordance with He-C 401.14(c).
8. You must be a resident of New Hampshire and submit proof of NH residency with your application. The following are acceptable forms of documentation. Originals are not required; legible copies of originals are acceptable. In all cases your name and current address must appear on the document you submit.
   a. New Hampshire driver's license (both sides);
   b. State or federal government-issued identification card that shows your name and address; or
   c. If documentation in a. and b. above is unavailable, other documentation that contains your name and current address and which indicates New Hampshire residency, such as a current lease agreement, tax documents from the previous calendar year, or a utility bill issued within the previous 2 months of the date of the application.
9. For applicants who are minors, proof of residency shall be provided for the applicant's custodial parent or legal guardian who will be the applicant's Designated Caregiver.
10. Mail or hand-deliver the completed application (pages 4–6 of this packet) and supporting documents to: NH Department of Health and Human Services, Therapeutic Cannabis Program, Brown Building, 129 Pleasant Street, Concord, NH 03301.

Items 4, 6, 7, and 8 must be included with your completed application.

APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS – QUALIFYING PATIENT

Instructions: Complete each page of this form. Sections or items labeled "Optional" need to be completed only if they apply to you. Please type or print in ink your responses on this form.

APPLICANT INFORMATION

☐ Initial Application ☐ Renewal Application	If a renewal application, your Registry ID Number		
Name	Last	First	Middle
Mailing Address	Street/P.O. Box	County	
	City	State	Zip Code
Phone Number			
Physical Address	(If different than mailing address) (If the applicant is homeless, this is not required)		
Date of Birth	MM/DD/YYYY	**NH Driver's License or State or Federal Government ID Number** (For minor applicants, provide this information for applicant's Designated Caregiver)	☐ I do not have this documentation, but other proof of NH Residency is included with this application.
E-Mail Address (optional)			

MEDICAL PROVIDER INFORMATION

Provide the following information about the medical provider who issued you the Written Certification for your qualifying condition.

Name	Last	First	
Business Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			

For minor applicants (under age 18), provide the following information about the medical provider who issued you the second Written Certification for your qualifying condition.

Name	Last	First	
Business Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			

MEDICAL INFORMATION RELEASE

I, hereby, authorize the release of relevant medical information by the provider(s) listed above to the NH Department of Health and Human Services if further information about my qualifying medical condition is required by the Department.

_____ _____

Signature of Applicant/Applicant's custodial parent or legal guardian **Date**

DESIGNATED CAREGIVER INFORMATION – OPTIONAL				
Name	Last		First	Middle
Mailing Address	Street/P.O. Box			
	City		State	Zip Code
Phone Number				
Physical Address	(If different than mailing address)			
Date of Birth	MM/DD/YYYY	**E-Mail Address (optional)**		

ALTERNATIVE TREATMENT CENTER

Check the box of the Alternative Treatment Center you have selected.

- ☐ Dover – Temescal Wellness
- ☐ Merrimack – Prime Alternative Treatment Centers of NH
- ☐ Lebanon – Temescal Wellness
- ☐ Plymouth – Sanctuary ATC

ADDITIONAL REQUIREMENTS FOR PATIENTS WHO ARE MINORS (UNDER AGE 18)

This section is required for any applicant who is under 18 years of age.

The applicant's custodial parent or legal guardian must initial each paragraph and certify that each paragraph is true.

Initials	
	I am the applicant's custodial parent or legal guardian who is responsible for the health care decisions of the applicant.
	The applicant's health care provider has explained to me the potential risks and benefits of the therapeutic use of cannabis.
	I consent to allow the applicant's therapeutic use of cannabis.
	I consent to serve as the applicant's Designated Caregiver and to control the acquisition of the cannabis and the frequency of the therapeutic use of cannabis by the applicant.
	I understand that if my application to be a Designated Caregiver is not approved, then the applicant's application to be a Qualifying Patient will not be approved.
	[If applicable] I share legal custody of the applicant, and have notified the other parent with legal custody of the minor applicant in advance of submitting this application by having provided to the other parent a copy of the completed Application Form and the completed Written Certification Forms.

CERTIFICATION

I, hereby, certify that the paragraphs initialed by me above are true and that I agree to comply with all requirements of the Therapeutic Cannabis Program. I understand that any false statements made on this application are punishable as unsworn falsification under RSA 641:3.

_____ _____

Signature of Custodial Parent or Legal Guardian **Date**

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

The applicant, or the applicant's custodial parent or legal guardian in the case of a minor applicant, must initial each paragraph to acknowledge his or her understanding of the information.

Initials	
	I understand that my Registry Identification Card is valid for one year, unless a shorter time period is indicated by my provider. I must renew my card every year by submitting another application and paying a $50 fee.
	I understand that if I am notified of a denial I have 30 days to appeal this decision from the time I receive notice of the denial, and that if a request for a hearing is not made within that timeframe then I will be deemed to have waived my right to a hearing and the action of the Department shall become final.
	I understand that if my application is approved and I am in possession of a Registry Identification Card, I may not possess, between myself and my Designated Caregiver, more than two ounces of usable cannabis.
	I understand that if my application is approved, I may only use therapeutic cannabis for the purpose of treating or alleviating my qualifying medical condition, as defined in RSA 126-X:1, IX.
	I understand that if my application is approved, I may not be under the influence of therapeutic 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 my place of employment, without the written permission of my employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.
	I understand that if my application is approved, I may not smoke or vaporize therapeutic 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 if my application is approved, I may not be in possession of therapeutic 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 I 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 have instructed a family member, caretaker, executor, and my Designated Caregiver that, in the event of my death, the Department shall be notified within 5 days that I have died. Within 5 days of learning of my death, the surviving family member, caretaker, executor, or my Designated Caregiver shall either request that the local law enforcement agency remove any remaining cannabis or dispose of the cannabis in a manner that is specified in RSA 126-X:2, XIV.
	I understand that if I am found to be in possession of therapeutic cannabis outside of my home and I am not in possession of my Registry Identification Card, I will 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 officer or for the use of cannabis other than use undertaken pursuant to RSA 126-X.
	I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within New Hampshire.
	I understand that I must be in compliance with RSA 126-X, Use of Cannabis for Therapeutic Purposes, and with administrative rules adopted thereunder, and that the Department may revoke my Registry Identification Card for any violation of any provision of RSA 126-X or any violation of the administrative rules adopted thereunder.
	I understand relevant federal policies, including that the use and possession of cannabis is a federal crime, and that by using cannabis I may be denied rights and privileges by federal agencies including, but not limited to, the loss of rights related to employment such as driving a commercial vehicle, the inability to pass a security clearance, and the loss of rights to own, possess, or purchase a firearm and/or ammunition.

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, certify that I am 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 and acknowledge that diversion of cannabis is punishable as a class B felony and will result in revocation of my Registry Identification Card, in addition to other penalties for the illegal sale of cannabis.

_____ _____

Signature of Applicant/Applicant's custodial parent or legal guardian **Date**