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

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MINOR 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: http://www.dhhs.nh.gov/oos/tcp/index.htm

General Requirements for Minor Patients (under age 18)

- The Minor Patient Application must be completed by the minor's custodial parent or legal guardian.
- The custodial parent or legal guardian must apply for and be approved as the minor's Designated Caregiver.
- This is a combined application for both the patient and the caregiver.
- A minor may have two Designated Caregivers, both of whom must be the patient's custodial parent or legal guardian.

Application Instructions

1. Read the "General Program Information" at the end of this application packet.
2. Complete ALL information on pages 1-3. Complete pages 4-5 if you want to provide voluntary demographic information.
3. **Submit with this Application Form**:
   a. Two "Written Certification for the Therapeutic Use of Cannabis" forms completed by two medical providers, one of whom must be a pediatrician.
   b. Proof of New Hampshire residency.* Submit ONE of the following:
      - A copy of your New Hampshire driver's license or New Hampshire State ID (front only); OR
      - Any other documentation that contains your 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 your name and NH address.

      **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, if the legal guardian is not a custodial parent.
      - If a minor patient applicant's legal guardian is not a custodial parent, the legal guardian must submit proof of legal guardianship with the 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:
☐ A completed Minor Patient Application ☐ Two completed Written Certifications (from two providers) ☐ Proof of NH residency (see 3b above) ☐ Application fee (see 3c above) ☐ Proof of guardianship (if not the custodial parent) (see 3d above) ☐ "Attestation of No Felony Conviction" form **(Renewal Only)** **(See 5 below for Initial application requirement)**	NH Department of Health and Human Services Therapeutic Cannabis Program 29 Hazen Drive Concord, NH 03301

APPLICATION INSTRUCTIONS (continued)

5. **Criminal Background Check Required (for the Designated Caregiver applicant only)**
   - For an initial application, you will need to have the results of a criminal history records check released to the Program before your application will be considered complete. Please see the "General Program Information" and the "Criminal Background Check Requirements and Instructions / Criminal History Record Information Authorization" form at the end of this application packet for specific instructions regarding the state and federal background check, which requires you to be fingerprinted. You must have no felony convictions on your record.
   - For a renewal application, a new criminal history records check is *not* required. Instead, you must submit a signed "Attestation of No Felony Conviction" form, which is included at the end of this application packet. If there is a lapse in your registration of more than one year, the results of a new criminal history records check are required.
6. 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 6a above will begin when the application is complete.

Notice Explaining Federal Law on the Possession of Cannabis (RSA 126-X:4, 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, the loss of rights related to employment such as driving a commercial vehicle, the inability to pass a security clearance, the denial or loss of federally subsidized housing, and the loss of rights to own, possess, or purchase a firearm and/or ammunition. (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 11.e on "ATF Form 4473." Note that this form was revised effective October 2016 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

MINOR PATIENT APPLICATION
FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: This application is to be completed by the minor patient's custodial parent or legal guardian.

☐ Initial Application

☐ Renewal Application (or expired/lapsed)

If an initial application, have you been fingerprinted and sent the required fee to the NH Department of Safety? ☐ Yes ☐ No

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

1. *Two completed Written Certifications (from the patient's medical providers)*
2. *A $50 application fee (check/money order, payable to "Treasurer – State of NH")*
3. *Proof of NH residency* (copy of NH license/State ID, current lease, recent utility bill, etc.)*
   **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*

MINOR PATIENT INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: _____	
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 INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: _____	
Phone Number		**E-Mail Address**	(optional)	
Mailing Address (if different than the patient)	Street/P.O. Box/Apt #			
	City		State	Zip Code
Physical Address	(If different than the patient)			

SECOND DESIGNATED CAREGIVER INFORMATION – OPTIONAL

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: _____	
Phone Number		**E-Mail Address**	(optional)	
Mailing Address (if different than the patient)	Street/P.O. Box/Apt #			
	City		State	Zip Code
Physical Address	(If different than the patient)			

MEDICAL PROVIDER INFORMATION

Provide information about the <u>two</u> medical providers who completed the Written Certifications. One of the providers must be a pediatrician.

Name	First	Last	
Business Address	Street/Suite #		
	City	State	Zip Code
Phone Number			

SECOND MEDICAL PROVIDER INFORMATION

Name	First	Last	
Business Address	Street/Suite #		
	City	State	Zip Code
Phone Number			

MEDICAL INFORMATION RELEASE

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

Parent/Guardian Signature		**Date**	

ALTERNATIVE TREATMENT CENTER **(Select only one box)**

- ☐ Dover – Temescal Wellness
- ☐ Lebanon / Keene – Temescal Wellness
- ☐ Merrimack / Chichester – Prime ATC
- ☐ Plymouth / Conway – Sanctuary ATC

DESIGNATED CAREGIVER REQUIREMENTS FOR A MINOR PATIENT

The Designated Caregiver(s) must attest to the following, by signing on the following page.

I am the applicant's custodial parent or legal guardian responsible for the health care decisions of the applicant.

The applicant's certifying providers have 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 cannabis and the frequency of the therapeutic use of cannabis by the applicant.

I understand that if I am not approved to be a Designated Caregiver, then the applicant's application to be a Qualifying Patient will not be approved.

(If applicable) I share legal custody of the applicant, and I have notified the other parent or guardian with legal custody of the applicant in advance of submitting this application by having provided to the other parent or guardian a copy of the completed Application form and the completed Written Certification forms.

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that Registry ID Cards are valid for one year, unless a shorter duration is indicated. Cards must be renewed every year by submitting another application and fee.
I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing 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 usable cannabis per Qualifying Patient.
I understand that as a Designated Caregiver I am not permitted to use therapeutic 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 therapeutic 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 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 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 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 my Qualifying Patient and 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 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 therapeutic 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 officer 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 therapeutic 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 therapeutic cannabis, and my Qualifying Patient, by using therapeutic 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 Designated Caregiver Requirements for a Minor Patient listed on Page 2 and the Acknowledgements listed above.

I, hereby, certify that the minor 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.

Parent/Guardian Signature		**Date**	
Second Parent/ 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 ☐ Cuban ☐ Another Hispanic, Latino/a, or Spanish origin

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

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

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
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ 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
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 or more

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

Are you currently enrolled in school?

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

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
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Never married
- ☐ 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
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ 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
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 or more

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

Are you currently enrolled in school?

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

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/oos/tcp/index.htm*
Applications and Forms: *https://www.dhhs.nh.gov/oos/tcp/applications-forms.htm*
Contact: *(603) 271-9333; TCP@dhhs.nh.gov; NH DHHS, Therapeutic Cannabis Program, 29 Hazen Dr., Concord, NH 03301*

Minimum Requirements for a Minor Qualifying Patient and their Designated Caregiver

- The minor patient must be a resident of New Hampshire.
- The minor patient must be diagnosed by two medical providers, one of whom must be a pediatrician, as having a qualifying medical condition that is listed in NH law.
- The custodial parent or legal guardian:
  - Must apply for and be approved as the minor's Designated Caregiver
  - Must be at least 21 years old
  - Must never have been convicted of a felony
- Both the patient and the caregiver must be issued a Registry ID Card by the Therapeutic Cannabis Program.
- A minor may have two Designated Caregivers, both of whom must be the patient's custodial parent or legal guardian.
- The Designated Caregiver must purchase and control the possession and frequency of use of the minor patient's cannabis.

Qualifying Medical Conditions

Two medical providers, one of whom must be a pediatrician, must certify that the minor patient has a qualifying medical condition that is listed in NH law, as follows:

- Moderate to severe chronic pain; OR
- Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects; OR
- Moderate or severe post-traumatic stress disorder ; OR
- Autism spectrum disorder (with an additional provider consultation requirement for the certifying provider); 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 that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects; 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 less than 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.
- Rescind 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

On the application you are required to select an Alternative Treatment Center (ATC) for the dispensing of therapeutic cannabis. You may select any of the ATCs, but you may select only one at any given time. You can purchase cannabis only 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. The ATCs in New Hampshire are as follows:

- **Prime Alternative Treatment Centers of NH**, 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: www.primeatc.com. Email: info@primeatc.com.
  Note: The **Merrimack** and **Chichester** dispensaries are considered to be the same ATC. Selecting Prime ATC allows you to go to both locations.
- **Sanctuary ATC**, with dispensaries located in **Plymouth** and **Conway**.
  568 Tenney Mountain Highway, Plymouth, NH 03264. Phone: (603) 346-4619
  234 White Mountain Highway (Route16), Conway, NH 03818. Phone: (603) 662-0113
  Website: www.sanctuaryatc.org. Email: info@sanctuaryatc.org.
  Note: The **Plymouth** and **Conway** dispensaries are considered to be the same ATC. Selecting Sanctuary ATC allows you to go to both locations.
- **Temescal Wellness**, with dispensaries located in **Dover**, and **Lebanon & 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: www.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383
  Note: The **Lebanon** and **Keene** dispensaries are considered to be the same ATC. Selecting this ATC allows you to go to both locations. The **Dover** dispensary is considered a separate ATC. Selecting the Dover location does not allow you to go to the other Temescal locations.

Criminal History Records Check (Designated Caregiver Applicant Only)

The initial application will not be considered complete until the NH Department of Safety, Division of State Police, has released the results of state and federal criminal history records check to the Program. This background check requires you to be fingerprinted, and to pay an additional fee to the NH Division of State Police.

- Follow the instructions on the second page of the "Criminal Background Check Requirements and Instructions / Criminal History Record Information Authorization for Therapeutic Cannabis" form, which is attached to the end of this application packet and available on the Program's website.
- The Division of State Police will conduct a criminal history records check through State and FBI records, and they will release to the Program whether or not you have been convicted of a felony.
- If, after two attempts, your fingerprints are invalid due to insufficient pattern, the Program may accept police clearances from every city, town, or county where you have lived during the past five years.

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

- A Registry ID Card is effective for one year (exception described above under "Medical Providers").
- 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
  - A new criminal records check is not required. Instead, you must submit a signed "Attestation of No Felony Conviction" form, which is available on the Program's website
- Submit your renewal materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.
- If there is a lapse in your registration of more than one year, you will be required to have the results of a new criminal history records check released to the Program.

CRIMINAL BACKGROUND CHECK REQUIREMENTS AND INSTRUCTIONS for DHHS THERAPEUTIC CANNABIS PROGRAM

If you are applying to be a Qualifying Patient, you DO NOT need a criminal history record check.

All Designated Caregivers and all Alternative Treatment Center (ATC) Agents must complete a state and federal criminal history record check. You must not have a felony conviction on your record.

- *Designated Caregivers* – A criminal history record check is required for an initial application for a Registry ID Card, or if there has been a lapse in registration of more than one year.
- *ATC Agents* – A criminal history record check is required prior to beginning to work for an ATC.

Preferred/Recommended Method

Use the "NH State Police Criminal Records Request Online Portal" to schedule your fingerprinting appointment and make payment ($48.25): **https://services.dos.nh.gov/chri/cpo/**. Go to your selected fingerprint station (listed below) at the selected time, and get fingerprinted. Results will be released to the Therapeutic Cannabis Program directly.

- ***Note:* The Authorization Form on the next page is not required if using the online portal.**
- *Note:* After you "Select Type of Agency: Therapeutic Cannabis," the agency that populates is "DHHS: ADMIN RULES UNIT." This is a known system error, which will be fixed in an upcoming release. This will not impact delivery of results to the Therapeutic Cannabis Program at 29 Hazen Drive in Concord.

Department of Safety Fingerprint Stations

These stations use LiveScan (digital) fingerprinting. Traditional inked fingerprint cards are not acceptable.

- **NH Department of Safety**: 33 Hazen Drive, Concord
- **DMV Dover Point:** 50 Boston Harbor Road, Dover
- **DMV Manchester Commons:** 377 South Willow Street, Manchester
- **DMV Salem:** 154 Main Street, Salem
- **Troop E:** 1863 White Mountain Highway, Tamworth
- **Troop C:** 15 Ash Brook Court, Keene
- **Troop F:** 549 Route 302, Twin Mountain

Alternate Methods

Department of Safety Fingerprinting Appointment Desk

1. Call the appointment desk at (603) 223-3867, during business hours, M-F, 8:15 am to 4:00 pm
   - Navigate the voice mail system
     - Select Option 2 from the first menu (ignore instruction to use the online portal)
     - Select Option 2 at the next prompt (ignore message about the emergency order / fingerprinting deferment still being in effect)
     - Leave name, phone number, and message, including the program you are applying for (eg, Therapeutic Cannabis Program). Please do not leave multiple messages.
2. Schedule a fingerprinting appointment with a DOS staff person (when they call you back) at one of the fingerprint stations listed above

Local Police Departments

Your local police department may be able to take your digital fingerprints if they have LiveScan

1. Call your local police station directly to see if they do LiveScan fingerprinting
2. If they do, schedule an appointment or walk-in, as available

The following instructions apply to both Alternate Methods above

3. Bring a photo ID to the appointment, such as a valid driver's license, state-issued photo ID, or passport
4. Within 30 days of being fingerprinted, submit the following materials to the following address:

Submit Required Materials:	To This Address:
☐ The "Criminal History Record Information Authorization for Therapeutic Cannabis" form (next page) ☐ A check for $48.25, payable to **State of NH–Criminal Records** ☐ The "Applicant/ Licensing LiveScan Fingerprinting" form given to you at the fingerprint station	Department of Safety, Division of State Police Criminal Records Unit 33 Hazen Drive Concord NH 03305

Note: If your fingerprint station is Concord, you can leave the materials above at the Concord station.

ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND MUST BE LEGIBLE. Incomplete forms may result in processing delays, additional fingerprinting, and costs. All signatures must be original. Photocopies are not accepted. Do not mail these forms and fees to the Therapeutic Cannabis Program.

Visit http://www.dhhs.nh.gov/oos/tcp/index.htm, or email TCP@dhhs.nh.gov, for additional Program information.

State of New Hampshire

Criminal Records Unit

Department of Safety
DIVISION OF STATE POLICE

33 Hazen Drive, Concord, NH 03305

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES CRIMINAL HISTORY RECORD INFORMATION AUTHORIZATION

THERAPEUTIC CANNABIS PROGRAM – RSA 126-X:4,8

This form is for DESIGNATED CAREGIVERS and ATC AGENTS only.
If you are applying to be a QUALIFYING PATIENT you DO NOT need to undergo a criminal history record check.

Please check one box: ☐ **Designated Caregiver** ☐ **ATC Agent (ATC Name_____)**

INSTRUCTIONS

NH RSA 106-B:14 and Administrative Rule Saf-C 5700 authorizes the dissemination of NH Criminal History Record Information (CHRI) for non-criminal justice purposes. In NH, all CHRI is confidential and released only upon the knowledge and permission of the individual for whom the request is made. Individuals requesting their own record in person need only to complete Section I. If the CHRI is to be released to a third party, both Section I and Section II must be completed.

SECTION I (PLEASE PRINT CLEARLY)

Last Name_____ **First Name**_____ **Maiden**_____ **MI**____

Address_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **Hair Color**_____ **Eye Color**_____ ☐ **Male** ☐ **Female**

Driver's License Number_____ **State**_____

My signature below signifies I am the individual listed above and the information provided is true.

Signature _____ **Date** _____

Signed under penalty of unsworn falsification pursuant to RSA 641:13

SECTION II (PLEASE PRINT CLEARLY)

I hereby authorize the release of my criminal record conviction(s), if any, to the following:

Name/Entity **NH Department of Health and Human Services – Therapeutic Cannabis Program**

Address **29 Hazen Drive** **City** **Concord** **State** **NH** **Zip** **03301**

Your Signature_____ **Date**_____

Notary's Signature **NOT APPLICABLE**

(Affix seal)

RECORD CHALLENGE

Saf-C 5703.12 Procedure for Correcting a CHRI (a) Persons or their attorneys desiring access to their CHRI for the purpose of challenge or correction shall appear at the central repository. (b) A copy shall be provided to a person if after review he/she indicates he/she needs the copy to pursue the challenge. (c) Any person making a challenge shall identify that portion of his/her CHRI which he/she believes to be inaccurate or incorrect, and shall also give a correct version of his/her record with an explanation of the reason that he/she believes his/her version to be correct. (d) The director shall take the following actions within 30 days of receipt of challenge: (1) Review the records and contact the law enforcement agency or court which submitted the record to compare the information to determine whether the challenge is valid; (2) If the challenge is valid, which means there is a discrepancy between the information submitted and the information maintained by the law enforcement agency or court, the record shall be corrected and the person and appropriate CJAs shall be notified; and (3) If the challenge is invalid, the person shall be informed and advised of the right to appeal pursuant to RSA 541. (e) When a record has been corrected, the division shall notify all non-criminal justice agencies, to whom the data has been disseminated in the last year, of the correction. (f) The person shall be entitled to review the information that records the facts, dates, and results of each formal stage of the criminal justice process through which he passes, to ensure that all such steps are completely and accurately recorded.

WARNING: The Division of State Police is the Criminal Record Repository for the State of New Hampshire. The record you have received is based only on what has been reported to the Repository and may not be a complete Criminal History Record of the named individual.

FEES

☐ **LIVESCAN - $48.25 if printed at a state police LiveScan site**

NOTE: Make checks payable to: State of NH – Criminal Records

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

Lori A. Shibinette
Commissioner

Patricia M. Tilley
Director

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

Designated Caregiver's Attestation of No Felony Conviction

(For Renewal Applications Only)

I, _____, have not been convicted of a felony
(*print first and last name*)

offense in this or any other state. I understand that any false statements made on this form are punishable as unsworn falsification under RSA 641:3.

Signature: _____ Date: _____

Instructions

- Designated Caregivers are not required to complete a new criminal history records check when they apply to renew their Registry ID Card for the Therapeutic Cannabis Program. Instead, Designated Caregivers must complete and submit this "Attestation of No Felony Conviction" form with their renewal application.
- If there has been a lapse in a Designated Caregiver's registration for the Therapeutic Cannabis Program of more than one year, the Designated Caregiver must complete a new state and federal criminal history records check.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
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603-271-9333 1-800-852-3345 Ext. 9333
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Fax: 603-271-8134 Email: TCP@dhhs.nh.gov

CAREGIVER DESIGNATION / REMOVAL

Please type or print clearly. See reverse side for complete instructions.

To be completed by Qualifying Patient:

Name: _____ Date of Birth: _____

Registry ID Card #: _____

☐ I designate _____ as my Designated Caregiver

☐ I remove _____ as my Designated Caregiver

_____ _____
Signature of Qualifying Patient *Date*

****

To be completed by Designated Caregiver:

Name: _____ Date of Birth: _____

☐ I accept designation to act as Designated Caregiver for the Qualifying Patient named above.

☐ I am currently a Designated Caregiver, and my Registry ID Card # is: _____

☐ I am not currently a Designated Caregiver. I understand that a complete Caregiver Application is required to be submitted to the Program. (See instructions on page 2)

☐ I will no longer serve as Designated Caregiver for _____

_____ _____
Signature of Designated Caregiver *Date*

Instructions for "Caregiver Designation / Removal" Form

Qualifying Patients. Use this form to:

(1) Designate a caregiver after you have been approved by the Program and have received your Registry ID Card:

a. Provide your name, date of birth, Registry ID Card number, signature, and date.
b. Provide the name of the person you wish to designate as your caregiver.
c. Have the person you wish to designate as your caregiver fill out the bottom of the form:
   - If the person is already a Designated Caregiver, you or the person designated must send the completed form to the Program; or
   - If the person is not already a Designated Caregiver:
     - You or the person designated must send the completed form to the Program; and
     - The person designated must submit a complete Caregiver Application to the Program and must be separately approved to be your Designated Caregiver. A Designated Caregiver must also have a criminal background check completed.

(2) Remove your current Designated Caregiver:

a. Provide your name, date of birth, and Registry ID Card number, and dated signature.
b. Provide the name of your Designated Caregiver you wish to remove.
c. Send the competed form to the Program.

(3) Remove your current Designated Caregiver and add a new Designated Caregiver.

a. Provide your name, date of birth, Registry ID Card number, signature, and date.
b. Provide the name of your Designated Caregiver you wish to remove.
c. Provide the name of the person you wish to designate as your caregiver.
d. Have the person you wish to designate as your caregiver fill out the bottom of the form:
   - If the person is already a Designated Caregiver, you or the person designated must send the completed form to the Program; or
   - If the person is not already a Designated Caregiver:
     - You or the person designated must return the completed form to the Program; and
     - The person designated must submit a complete Caregiver Application to the Program and be separately approved to be your Designated Caregiver. A Designated Caregiver must also have a criminal background check completed.

Designated Caregivers. Use this form to:

(1) Accept a Qualifying Patient's designation as a Designated Caregiver:

a. After a Qualifying Patient has filled out the top of the form, provide your name, date of birth, signature, and date.
b. Indicate if you are currently a Designated Caregiver for someone else, and if so, provide your Registry ID Card number.
c. Indicate if you are not currently a Designated Caregiver. NOTE: You are required to submit a complete Caregiver Application to the Program and be separately approved to be the patient's caregiver if (1) you have never been a Designated Caregiver or (2) you were previously a Designated Caregiver but your caregiver status has expired. Please contact the Program for assistance. A Designated Caregiver must also have a criminal background check completed.
d. You or the Qualifying Patient must send the completed form to the Program.

(2) Stop being a Designated Caregiver for a Qualifying Patient:

a. Provide your name, date of birth, Registry ID Card number, signature, and date.
b. Provide the name of the patient for whom you will no longer serve as Designated Caregiver.
c. Send the completed form to the Program.

Resources

Caregiver Application: http://www.dhhs.nh.gov/oos/tcp/documents/applicationcaregiver.pdf
Criminal Record History Authorization Form: http://www.dhhs.nh.gov/oos/tcp/documents/criminalrecordsform.pdf