

Lori A. Shibinette  
Commissioner

Patricia M. Tilley  
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](mailto:TCP@dhhs.nh.gov)

**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>

1. Read the “General Program Information” at the end of this application packet.
2. Complete ALL information on pages 1 and 3. Complete page 2 if you want to designate a caregiver or if you want to provide voluntary demographic information.

3. **Submit with this Application Form:**

- The “Written Certification for the Therapeutic Use of Cannabis” form completed by your medical provider.
  - 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.*
- 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.

4. Mail or hand-deliver the following:

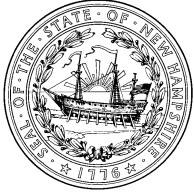
Required Documents:	To This Address:
<input type="checkbox"/> A completed Patient Application <input type="checkbox"/> A completed Written Certification (from your provider) <input type="checkbox"/> Proof of NH residency (see 3b above) <input type="checkbox"/> Application fee (see 3c above)	NH Department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

5. Application processing:

- 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.
- 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 above will begin when the application is complete.

6. Other Applications:

- If the applicant is a minor, use the “Minor Patient Application,” which is a combined patient/caregiver application.
- If the applicant is an adult with a guardian, AND the guardian is applying to be the patient’s Designated Caregiver, use the “Guardianship Patient Application.” See the “General Program Information” at the end of this application packet.



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**RSA 126-X:4, VI – NOTICE EXPLAINING FEDERAL LAW  
ON THE POSSESSION OF CANNABIS**

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>

## PATIENT APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

**Instructions:** Complete pages 1 and 3 of this form.  
Complete page 2 to designate a caregiver and/or to provide voluntary demographic information.

- 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 your medical provider)
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

### PATIENT INFORMATION

<b>Name</b>	First	Last	Middle
<b>Date of Birth</b>	MM/DD/YYYY	<b>Gender</b>	<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: _____
<b>Phone Number</b>		<b>E-Mail Address (optional)</b>	
<b>Mailing Address</b>	Street/P.O. Box/Apt #		
	City	State	Zip Code
<b>Physical Address</b>	(If different than mailing address) (If experiencing homelessness, this is not required)		

### MEDICAL PROVIDER INFORMATION

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

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

### 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 my qualifying medical condition or Written Certification is required.

**Applicant's Signature**

**Date**

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

- |   |  |
|---|--|
| <input type="checkbox"/> Dover – Temescal Wellness          | <input type="checkbox"/> Lebanon / Keene – Temescal Wellness |
| <input type="checkbox"/> Merrimack / Chichester – Prime ATC | <input type="checkbox"/> Plymouth / Conway – Sanctuary ATC   |

## DESIGNATE A CAREGIVER – OPTIONAL

**Instructions:** Read the “Designate a Caregiver” section at the end of this application packet. The person you designate below must submit a “Caregiver Application,” submitted separately or with this application.

Is a “Caregiver Application” enclosed or has it already been submitted for the person listed below?  Yes  No

<b>Name</b>	First	Last	Middle
<b>Mailing Address</b>	Street/P.O. Box/Apt #		
	City	State	Zip Code
<b>Date of Birth</b>	MM/DD/YYYY		

## 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)

- |   |   |
|---|---|
| <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?

- |   |   |
|---|---|
| <input type="checkbox"/> Less than \$25,000   | <input type="checkbox"/> \$75,000 to \$99,999 |
| <input type="checkbox"/> \$25,000 to \$49,999 | <input type="checkbox"/> \$100,000 or more    |
| <input type="checkbox"/> \$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: \_\_\_\_\_

## THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that my Registry ID 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, certification, 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 Designated Caregiver, more than two ounces of usable cannabis.

I understand that I may only use therapeutic cannabis for the purpose of treating or alleviating my qualifying medical condition.

I understand that 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 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 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, and that within 5 days of learning of my death, the 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 ID 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 granted by RSA 126-X for the therapeutic use of cannabis apply only within New Hampshire.

I understand that I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke my Registry ID Card for any violation of any provision of RSA 126-X or the rules adopted thereunder.

I understand that by using therapeutic cannabis I 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 Acknowledgements listed above.

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, 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.

**Applicant's  
Signature**

**Date**

# 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](mailto:TCP@dhhs.nh.gov); NH DHHS, Therapeutic Cannabis Program, 29 Hazen Dr., Concord, NH 03301

## **Minimum Requirements to Become a Qualifying Patient**

- You must be a resident of New Hampshire.
- You must be diagnosed by a medical provider as having a qualifying medical condition that is listed in NH law.
- You must apply for and be issued a valid Registry ID Card by the Therapeutic Cannabis Program (TCP).

## **Qualifying Medical Conditions**

Your medical provider must certify that you have 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 those under age 21); 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 YOU FOR THE THERAPEUTIC CANNABIS PROGRAM.**

- Talk with any of your current medical providers about your interest in the Program. Ask if they will certify you by issuing you 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.

Your 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 your certification at any time and for any reason if in the provider's opinion you should no longer be certified for the therapeutic use of cannabis.

## **Designate a Caregiver**

If you need help with your therapeutic use of cannabis, including help with obtaining cannabis from your ATC, you may designate someone to be your *caregiver*. You may do this on your application or any time after you've been approved (use the Caregiver Designation/Removal" form on the Program's website). You may designate only one caregiver at a time. **Your caregiver must submit a separate "Caregiver Application"** and be issued a Registry ID Card before your caregiver can legally assist you with your therapeutic use of cannabis. The caregiver's Registry ID Card will allow that person to legally possess cannabis on your behalf and to legally purchase cannabis from your ATC.

To be approved as a Designated Caregiver, a person must be at least 21 years old and must never have been convicted of a felony. Your caregiver must undergo a state and federal criminal background check, which includes being fingerprinted, and which requires an additional fee paid to the NH Department of Safety, Division of State Police.

## GENERAL PROGRAM INFORMATION (Continued)

### Alternative Treatment Centers

On your 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](http://www.primeatc.com). Email: [info@primeatc.com](mailto: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 (Route 16), Conway, NH 03818. Phone: (603) 662-0113  
Website: [www.sanctuaryatc.org](http://www.sanctuaryatc.org). Email: [info@sanctuaryatc.org](mailto: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](http://www.temescalwellness.com). Email: [info@temescalwellness.com](mailto: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.

### Confidentiality

The Program will maintain the confidentiality of all personal information about applicants, Qualifying Patients, Designated Caregivers, and certifying medical providers submitted to the Program and 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.

### Requirements for Minor Patients (under 18 years of age)

Use the "Minor Patient Application" located on the Program's website.

### Requirements for Adult Patients Who Have a Legal Guardian or Co-Guardians

- If the legal guardian(s) will be the patient's Designated Caregiver, please use the "Guardianship Patient Application" located on the Program's website.
- If the legal guardian is signing *this* Patient Application on behalf of the patient but will *not* be the patient's Designated Caregiver, proof of guardianship must be submitted with 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.

### Renewals

- A Registry ID Card is effective for one year (exceptions are 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.
- Please use the same Patient Application and Written Certification forms for renewals.
- Submit your renewal application materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.