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

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GUARDIANSHIP PATIENT APPLICATION
For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

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

General Instructions for an Adult Patient with a Legal Guardian

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

Application Instructions

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

      **If proof of residency is not available for the patient applicant, submit it for one of the Designated Caregiver applicants.*

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

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

APPLICATION INSTRUCTIONS (continued)

5. Application processing:
   a. Application processing takes up to 3 weeks.
      - The Program will approve or deny a complete application within 15 days of receipt.
      - The Program will issue a Registry ID Card within 5 days of approval.
   b. Incomplete applications:
      - You will be notified in writing within 10 days of receipt if an application is incomplete.
      - You will be asked to submit the missing information/documentation within 30 days from the date of the notice.
      - If you don't provide the missing information/documentation within 6 months of the notice, your application will be closed. You will need to reapply by resubmitting ALL required application materials, including the fee.
      - The processing times listed in 5a above will begin when the application is complete.

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

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

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

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

OTHER FEDERAL IMPLICATIONS

Qualifying patients who use cannabis may be denied rights and privileges by federal agencies including, but not limited to, 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

GUARDIANSHIP PATIENT APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

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

☐ Initial Application

☐ Renewal Application (or expired/lapsed)

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

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

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

PATIENT INFORMATION

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

DESIGNATED CAREGIVER (GUARDIAN) INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender:**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: _____	
Phone Number				
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 (GUARDIAN) 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				
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 medical provider who completed the Written Certification.

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 provider listed above to the NH DHHS if additional information about the qualifying medical condition or Written Certification is required.

Legal Guardian Signature		**Date**	

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGMENTS

I understand that Registry ID Cards are valid for one year, unless a shorter 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 cannabis per Qualifying Patient, or obtain more than 2 ounces of cannabis in any 10-day period from any source per Qualifying Patient.
I understand that as a Designated Caregiver I am not permitted to use 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 Acknowledgments listed above.

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

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

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

Legal Guardian Signature		**Date**	
Second Legal Guardian Signature (if applicable)		**Date**	

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

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

PATIENT INFORMATION

Race/Ethnicity

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

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

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

- ☐ White
- ☐ 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: _____

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

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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:_____

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

General Instructions/Requirements for Adult Patients with a Legal Guardian

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

Qualifying Medical Conditions

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

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

All NH-registered patients and caregivers can go to any of the 7 Alternative Treatment Center dispensary locations in the state. 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.

- **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.

- **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

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:
  1. Proof of NH residency is not required if there has not been a change of address
- Submit your renewal materials at least 30 days prior to your card’s expiration to prevent a lapse in your registration.

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
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.

(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.

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.
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 and other forms and information: https://www.dhhs.nh.gov/tcp