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

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

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 and/or if you want to provide voluntary demographic information.
3. **Submit with this Application Form**:
   3a) The "Written Certification for the Therapeutic Use of Cannabis" form completed by your medical provider.
   3b) 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.*

   3c) 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:
☐ A completed Patient Application ☐ A completed Written Certification (from your provider) ☐ Proof of NH residency (see 3b above) ☐ 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.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

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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

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	Street/P.O. Box/Apt #			
	City		State	Zip Code
Physical Address	(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.

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 my qualifying medical condition or Written Certification is required.

Applicant's Signature		**Date**	

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

Name	First	Last	Middle
Mailing Address	Street/P.O. Box/Apt #		
	City	State	Zip Code
Date of Birth	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)
- ☐ 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: _____

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGMENTS

I understand that my Registry ID Card is valid for one year, unless a shorter or longer duration is indicated by my provider. I must renew or extend my card prior to its expiration in order to prevent a lapse in registration.

I understand that if I am notified of a denial or a revocation I have 30 days from the date of the notice to appeal the decision, and that if an appeal request is not made within that timeframe then I will have waived my right to an appeal and the action of the Department shall become final.

I understand that I may not possess, between myself and my Designated Caregiver, more than 2 ounces of cannabis, or obtain more than 2 ounces of cannabis in any 10-day period from any source.

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

I understand that I may not be under the influence of cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in 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 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 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 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 official or for the use of cannabis other than use undertaken pursuant to RSA 126-X.

I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis 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 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 Acknowledgments 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**	

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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*

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
- 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 is 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 (MD/DO), PHYSICIAN ASSISTANT (PA), OR ADVANCED PRACTICE REGISTERED NURSE (APRN) 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.

GENERAL PROGRAM INFORMATION (Continued)

Alternative Treatment Centers

There are seven Alternative Treatment Center (ATC) dispensaries operating in New Hampshire for dispensing therapeutic cannabis. A registered Qualifying Patient, or their Designated Caregiver, is allowed to purchase cannabis from any ATC location in the state. You must show your Registry ID Card and valid photo identification to enter one of the ATC dispensaries. It's recommended that you call the ATC before your first visit to a new dispensary. 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: nh.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383

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: https://www.dhhs.nh.gov/tcp-forms

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: https://www.dhhs.nh.gov/tcp-forms
- If the legal guardian is signing *this* Patient Application on behalf of the patient, 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, unless your card has been expired for more than six months.
- There is no penalty for renewing after the suggested deadline, however, we ask that you submit your renewal application materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.

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.

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CAREGIVER APPLICATION
For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

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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 provide voluntary demographic information.

3. Mail or hand-deliver the following:

Required Documents:	To This Address:
☐ A completed Caregiver Application ☐ A completed Caregiver Designation form (if you are not designated on the Patient Application, Page 2)	NH Department of Health and Human Services Therapeutic Cannabis Program 29 Hazen Drive Concord, NH 03301

4. In order for your application to be complete, your patient must designate you as their caregiver on their "Patient Application" or on the "Caregiver Designation/Removal" form, and your patient must be approved and be issued a Registry ID Card.

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 if your patient has an active card.
   b. Incomplete applications:
      - You will be notified in writing within 10 days 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.
      - The processing times listed in 5a above will begin when the application is complete.

6. Other applications:
   a. If your patient is a minor (under age 18), use the "Minor Patient Application," which is a combined patient/caregiver application.
   b. If your patient is an adult and you are the legal guardian who will sign on behalf of the patient, AND you are applying to be the patient's Designated Caregiver, use the "Guardianship Patient Application," which is a combined patient/caregiver application.

A criminal background check for Caregivers is no longer required.

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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

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FEDERAL FIREARMS NOTICE

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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

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- 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

CAREGIVER APPLICATION
FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: Complete pages 1 and 3 of this form.
Complete page 2 to provide voluntary demographic information.

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

Minimum Requirements to be a Caregiver:
- *You must be at least 21 years old.*
- *You must never have been convicted of a felony.*

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				
Mailing Address	Street/P.O. Box/Apt #			
	City		State	Zip Code
Physical Address	(If different than mailing address)			

PATIENT INFORMATION

Provide information about the Patient who has designated you as their Caregiver

Name	First	Last	Middle
Mailing Address	Street/P.O. Box/Apt #		
	City	State	Zip Code
Physical Address	(If different than mailing address) (If patient is experiencing homelessness, this is not required)		
Date of Birth	MM/DD/YYYY		

You may be the Caregiver for up to five Patients.
Additional Patients may be added by completing additional copies of this page.

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

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

CAREGIVER INFORMATION

Race/Ethnicity

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

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

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that my Registry ID Card is valid for one year, unless a shorter or longer duration is indicated by my patient's medical provider. I must renew or extend my card prior to its expiration to prevent a lapse in registration.

I understand that if I am notified of a denial or a revocation I have 30 days from the date of the notice to appeal the decision, and that if an appeal request is not made within that timeframe then I will have waived my right to an appeal and the action of the Department shall become final.

I understand that I may not possess, between myself and my Qualifying Patient(s), more than 2 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 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 I may not be in possession of cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.

I understand that 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 I am found to be in possession of cannabis outside of my home and I am not in possession of my Registry ID Card, I may be subject to a fine of up to $100.

I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement official or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.

I understand that the protections conferred 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 I, by possessing cannabis, and my Qualifying Patient, by using cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federally subsidized housing, those related to immigration and naturalization, or the inability to pass a security clearance.

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Acknowledgments listed above.

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

I, hereby, agree to act as the Designated Caregiver for the Qualifying Patient(s) named in this Application, and I certify that 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

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*

Minimum Requirements to Become a Designated Caregiver

- You must be at least 21 years old.
- You must never have been convicted of a felony.
- You must be designated as caregiver on your patient's application or Caregiver Designation form, and that patient must be approved for the Program.

Number of Qualifying Patients Allowed

You may be the Designated Caregiver for up to five patients.

An exception to this limit is if both you and any patients over and above five live more than a 50-mile drive from the nearest Alternative Treatment Center (ATC), in which case you may be the Designated Caregiver for up to nine patients. For example, if you want to have six patients, both you and at least one of the six patients must live more than a 50-mile drive from the nearest ATC.

Designated Caregiver's List of Qualifying Patients

The Program will provide you with a current list of your patients' Registry Identification numbers. The Program strongly advises that you carry this document with you when transporting or possessing therapeutic cannabis. The information contained in the document is confidential; however, it may be shared with law enforcement officers to document how many ounces of cannabis you are permitted to possess (ie, 2 ounces per patient).

Compensation

You may receive compensation from your patient for actual costs, such as gas, tolls, and the costs of any cannabis products purchased, but not for any time or labor associated with assisting your patient(s) with their therapeutic use of cannabis.

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.

Renewals

- A Registry ID Card is effective for one year.
- Please use this same application form for renewals.
- Submit your renewal application materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.

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 if your patient has an active card.

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.
- The processing times listed above will begin when the application is complete.

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: http://www.dhhs.nh.gov/tcp-forms

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

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603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
Fax: 603-271-8134 Email: TCP@dhhs.nh.gov

WRITTEN CERTIFICATION WITHDRAWAL

A certifying provider may rescind or withdraw a Written Certification which the provider previously issued, for cause. [*See* RSA 126-X:4, IX(b); He-C 401.06(f)]

Mail or fax this completed form to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301
Fax: (603) 271-8134

Please type or print clearly.

Patient Name: _____

Patient Date of Birth: _____

Certifying Provider Name: _____

Practice Phone Number: _____

Statement of Withdrawal

I hereby withdraw the Written Certification for the Therapeutic Use of Cannabis issued by me for the Qualifying Patient listed above because I have determined that this patient:

- ☐ No longer has a qualifying medical condition
- ☐ Should discontinue using cannabis
- ☐ Falsified information that was the basis of the Written Certification
- ☐ Did not adhere to the treatment plan
- ☐ Should no longer be certified for the therapeutic use of cannabis for another compelling reason:

_____

_____

_____

_____ _____

Signature of Certifying Provider **Date**

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WRITTEN CERTIFICATION EXTENSION

If a Written Certification has been previously issued for less than 3 years, the **same certifying provider** who issued that Written Certification may extend that Written Certification by completing and submitting this form.

- The total duration of the Written Certification, including any extensions, **shall not exceed 3 years**.
- This "Written Certification Extension" request does not require the submission of a new Written Certification, or a new Patient Application and fee.
- If an extension duration is indicated below which exceeds the maximum of 3 years from the original effective date, the extension duration shall default to the maximum duration allowed.

IMPORTANT. If the following requirements are not met, the patient will need to reapply by submitting a new Written Certification and a new Patient Application and Application Fee:

- This form must be signed and dated by the same certifying provider prior to the expiration of the patient's Registry ID Card.
- This form must be received by the program no later than one month after the patient's Registry ID Card expires.

Mail or fax the completed form to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301
Fax: (603) 271-8134

Please type or print clearly.

Patient Name: _____ Patient Date of Birth: _____

Certifying Provider Name: _____

Certifying Provider Medical License Number: _____ Practice Phone: _____

Expiration Date of Patient's Current Registry ID Card (if known): _____

Length of Extension: ☐ Maximum allowed ☐ Other duration _____

_____ _____
Signature of Certifying Provider **Date**

STATE OF NEW HAMPSHIRE

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THERAPEUTIC CANNABIS PROGRAM

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Commissioner

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Email: tcp@dhhs.nh.gov

WRITTEN CERTIFICATION
For the Therapeutic Use of Cannabis

INSTRUCTIONS FOR MEDICAL PROVIDERS

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

1. The medical provider must complete ALL information on this Written Certification. Failure to complete this form in its entirety will cause your patient's application to be incomplete and the Written Certification to be returned to you.
2. Give the completed Written Certification to your patient to submit to the Program. DO NOT send the form directly to the Program; it should accompany the Patient Application.
3. Your patient will need to submit the following items to the Program:
   (1) A completed Written Certification;
   (2) A completed Patient Application;
   (3) A $50 application fee; and
   (4) Proof of NH residency.
4. The Program will notify you in writing once a determination has been made regarding your patient's application.
5. In order to certify a patient for the Program, you must be a "provider" as defined in NH law:
   (1) A NH physician licensed to prescribe drugs to humans under RSA 329;
   (2) A NH advanced practice registered nurse (APRN) licensed to prescribe drugs to humans under RSA 326-B:18;
   (3) A NH physician assistant (PA) licensed under RSA 328-D, with the express consent of the supervising physician; or
   (4) A physician or APRN licensed to prescribe drugs to humans under state licensing laws in Maine, Massachusetts, or Vermont, and who is primarily responsible for the patient's care related to the patient's qualifying medical condition.

   All providers must have an active registration from the US DEA to prescribe controlled substances.
6. Your patient must have a "qualifying medical condition" as defined in NH law. See page 2 for a complete list of qualifying medical conditions.
7. You must have a "provider-patient relationship" with your patient. See page 3 for a description of the requirements of a provider-patient relationship.
8. The Program will accept a Written Certification up to 6 months from the date of your signature.
9. You may send dispensing instructions/recommendations to the Alternative Treatment Centers (ATCs). The ATCs must comply with any such instructions. See the "Medical Provider Information Sheet" for more information.

THIS FORM IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE THERAPEUTIC USE OF CANNABIS

WRITTEN CERTIFICATION
FOR THE THERAPEUTIC USE OF CANNABIS

To be completed by the certifying medical provider

☐ Initial Certification
☐ Renewal Certification

Note to Patient: *These items are required to be submitted with this Certification:*

1. *A completed Patient Application*
2. *A $50 application fee (check/money order, payable to "Treasurer – State of NH")*
3. *Proof of NH residency (NH license/State ID, current lease, recent utility bill, etc.)*

PATIENT INFORMATION

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

PROVIDER INFORMATION

Name of Provider	First		Last		Middle
Name of Medical Practice					
Office Mailing Address	Street				Suite
	City		State		Zip Code
Office Phone/Fax Number	Phone	Extension	Fax		
E-Mail Address (optional)					
State License Number			☐ Physician (MD, DO) ☐ Physician Assistant (PA) ☐ Advanced Practice Registered Nurse (APRN)		
DEA Number					
Medical Specialty					

THIS FORM IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE THERAPEUTIC USE OF CANNABIS

PROVIDER'S CERTIFICATION OF A PATIENT'S QUALIFYING MEDICAL CONDITION

Patient's Name:

_____

(First and last name)

IMPORTANT INSTRUCTIONS – PLEASE READ:

1. Include the patient's name
2. Complete EITHER Box A – Condition / Symptom (both sections), OR Box B – Condition Only
3. Sign and date at the bottom of the page

A. Condition / Symptom (Check all that apply)

I certify that I am treating the patient named above, who has the following condition(s):

- ☐ Acquired immune deficiency syndrome
- ☐ Alzheimer's disease
- ☐ Amyotrophic lateral sclerosis
- ☐ Cancer
- ☐ Chronic pancreatitis
- ☐ Crohn's disease
- ☐ Ehlers-Danlos syndrome
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ One or more injuries or conditions that has resulted in one or more qualifying symptoms listed below
- ☐ Parkinson's disease
- ☐ Positive status for human immunodeficiency virus
- ☐ Spinal cord injury or disease
- ☐ Traumatic brain injury
- ☐ Ulcerative colitis

AND who has a severely debilitating or terminal medical condition, or its treatment, that has produced at least one of the following qualifying symptoms or side effects:

- ☐ Agitation of Alzheimer's disease
- ☐ Cachexia
- ☐ Chemotherapy-induced anorexia
- ☐ Constant or severe nausea
- ☐ Elevated intraocular pressure
- ☐ Moderate to severe insomnia
- ☐ Moderate to severe vomiting
- ☐ Seizures
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects
- ☐ Severe, persistent muscle spasms
- ☐ Wasting syndrome

OR

B. Condition Only (Check all that apply)

I certify that I am treating the patient named above, who has the following condition(s):

- ☐ Autism spectrum disorder (age 21 and older)
- ☐ Autism spectrum disorder (under age 21) (*See additional certification requirement on page 3*)
- ☐ Moderate or severe post-traumatic stress disorder
- ☐ Moderate to severe chronic pain
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects

I certify that I am treating the patient named above for the following condition:

- ☐ Opioid use disorder with associated symptoms of cravings and/or withdrawal

Requires a provider who is board-certified in Addiction Medicine or Addiction Psychiatry:

Certification Board Name: _____ Certification Number: _____

Provider's Signature		**Date**	

PROVIDER'S CERTIFICATION OF A PROVIDER-PATIENT RELATIONSHIP

A ***provider-patient relationship*** is a medical relationship between a licensed provider and a patient during which the provider has conducted a full assessment of the patient's medical history and current medical condition.

Per He-C 401.06(b)(4), a ***full assessment*** shall include an in-person physical examination of the patient; a medical history of the patient, including a prescription history; a review of laboratory testing, imaging, and other relevant tests; appropriate consultations; a documented diagnosis of the patient's current medical condition; and the development or documentation of a treatment plan for the patient appropriate for the provider's specialty.

Autism Spectrum Disorder Certification for Patients Under Age 21 (if applicable). I certify that I have consulted with a certified provider of child and/or adolescent psychiatry, developmental pediatrics, or pediatric neurology, who has confirmed that the autism spectrum disorder has not responded to previously prescribed medication or for which other treatment options produced serious side effects, and who supports certification for the therapeutic use of cannabis.

I certify that:

I have completed a full assessment of my patient's medical history and current medical condition in accordance with He-C 401.06(b)(4) made in the course of a provider-patient relationship.

I certify that:

I have explained the potential health effects of the therapeutic use of cannabis to my patient.

If my patient is a minor, I have explained to my patient's custodial parent or legal guardian with responsibility for health care decisions for the patient both the potential health effects and the potential risks and benefits of the therapeutic use of cannabis.

If my patient is a woman of child-bearing age, I have counseled my patient (and the custodial parent or legal guardian if a minor) about the risks of cannabis use during pregnancy and while breastfeeding.

If my patient is an adolescent 25 years of age or less, I have counseled my patient (and the custodial parent or legal guardian if a minor) about the risks of cannabis use in adolescence.

I certify that I am:

A physician, an APRN, or a PA licensed in New Hampshire to prescribe drugs to humans under RSA 329, 326-B:18, or 328-D, respectively, and who possesses an active registration from the US DEA to prescribe controlled substances

OR

A physician or an APRN licensed in Maine, Massachusetts, or Vermont to prescribe drugs to humans under the relevant state licensing laws, who possesses an active registration from the US DEA to prescribe controlled substances, and who is primarily responsible for my patient's care related to my patient's qualifying medical condition.

I certify that:
I possess an active license in good standing with the State of New Hampshire, or the State of Maine, Massachusetts, or Vermont, and the facts as stated in this Written Certification are accurate to the best of my knowledge and belief. I understand that false statements made on this Written Certification are punishable as unsworn falsification under RSA 641:3.

Provider's Signature		Date	

Telemedicine. Per He-C 402.06(b)(4)a., the ***in-person physical examination*** of the patient shall not be via telemedicine for the initial certification. Telemedicine is allowed for follow-up visits and for recertifications by the same provider.

YOU MUST CHECK ONE BUTTON BELOW.

- ◯ This Certification is based on an **in-person** physical examination. *(Required for initial certification.)*
- ◯ This Certification is based on an examination conducted via **telemedicine**. *(Allowed for recertification by the same provider.)*

DURATION OF WRITTEN CERTIFICATION

Your patient's Registry ID Card will be effective for 12 months from the effective date of the card. If the patient's card should be valid for a period shorter than 12 months, or longer (up to a maximum of 36 months), indicate the number of months the card shall remain valid.

The Registry ID Card shall remain valid for the following duration:

☐ 3 months ☐ 6 months ☐ 12 months (default) ☐ 18 months ☐ 24 months ☐ 36 months (maximum)

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

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email: TCP@dhhs.nh.gov

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: https://www.dhhs.nh.gov/tcp

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, one of whom must be a Pediatrician)* ☐ Proof of NH residency (see 3b above) ☐ Application fee (see 3c above) ☐ Proof of guardianship (if not the custodial parent) (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: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)

***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			
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			
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**	

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 ACKNOWLEDGMENTS

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

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Designated Caregiver Requirements for a Minor Patient listed on Page 2 and 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 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:_____

(This page intentionally left blank to allow for double-sided printing)

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*

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
- 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 is 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 (MD/DO), PHYSICIAN ASSISTANT (PA), OR ADVANCED PRACTICE REGISTERED NURSE (APRN) 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**, **Lebanon**, and **Keene**.
  26 Crosby Road, Units 11-12, Dover, NH 03820
  367 Route 120, Unit E-2, Lebanon, NH 03766
  69 Island Street, Suite 1, Keene, NH 03431
  Website: nh.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383

Confidentiality

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

Renewals

- 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
- 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

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

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

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Acknowledgments listed above.

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

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

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

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

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

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

PATIENT INFORMATION

Race/Ethnicity

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

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

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**, **Lebanon**, and **Keene**.
  26 Crosby Road, Units 11-12, Dover, NH 03820
  367 Route 120, Unit E-2, Lebanon, NH 03766
  69 Island Street, Suite 1, Keene, NH 03431
  Website: nh.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383

Confidentiality

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

Renewals

- 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

STATE OF NEW HAMPSHIRE

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29 HAZEN DRIVE, CONCORD, NH 03301
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
Fax: 603-271-8134 Email: TCP@dhhs.nh.gov

CHANGE OF INFORMATION / LOST CARD

Please type or print clearly.

Name: _____ Date of Birth: _____

Phone Number: _____ Registry ID Card #: _____
(if available)

Check the box of the change(s) you want to make. See reverse side for complete instructions.

☐ **Change of Name**

*Provide **new** name:* _____

☐ **Change of Address**

*Provide **new MAILING** address:*

_____

_____

_____

*Provide **new PHYSICAL** address:*

_____

_____

_____

☐ **Lost, Stolen, or Destroyed Registry ID Card**

To request a replacement card, include a check or money order for $10 made payable to "Treasurer – State of New Hampshire"

Instructions for "Change of Information / Lost Card" Form

Change of Name or Address

- You must notify the Program within 10 days of any change to your name or address.
- Provide your new name and/or your new address in the space provided.
- The Program will issue a new Registry ID Card within 20 days of receiving your request.
- There is no fee required for this change.

The completed form can be mailed, faxed, or emailed to:

Mailing address: NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301

Fax: (603) 271-8134

Email: TCP@dhhs.nh.gov

Lost, Stolen, or Destroyed Registry ID Card

- You must notify the Program within 10 days of your card being lost, stolen, or destroyed.
- To receive a replacement card, include a check or money order for $10 made payable to "**Treasurer – State of New Hampshire**"
- The Program will issue a new Registry ID Card within 5 days of receiving your request.

The completed form and payment can be mailed to:

Mailing address: NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301

To add, remove, or change a **Designated Caregiver**, use the "Caregiver Designation / Removal" form available at https://www.dhhs.nh.gov/tcp-forms.

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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