State of Illinois
Illinois Department of Public Health

MQP

Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card for Qualifying Patients Under 18 Years of Age and their Designated Caregiver

Do not use this form for Terminal Illness

MINOR QUALIFYING PATIENT INFORMATION

Social Security Number (###-##-####)	Driver's License Number	Driver's License State	No Driver's License ❑
First Name	Middle Name	Last Name	
Home Address		Apartment or Suite Number	
City	County	State IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address		
Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female		

RECOMMENDING PHYSICIAN INFORMATION

First Name	Middle Name	Last Name	
Office Address			
Suite Number	City	State IL	ZIP Code

REVIEWING PHYSICIAN INFORMATION

First Name	Middle Name	Last Name	
Office Address			
Suite Number	City	State IL	ZIP Code

SIGNATURE OF MINOR, IF AGE 16 OR OLDER _____ DATE (mm/dd/yyyy) _____

This application was prepared by:

PRINT/TYPE PREPARER'S NAME _____ DATE (mm/dd/yyyy) _____

FIRM OR ORGANIZATION NAME _____ PHONE NUMBER _____

Printed by Authority of the State of Illinois
P.O.#3117023 1M 11/16

IOCI 17-247

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MEDICAL CANNABIS DISPENSARY SELECTION

Name and Address of Dispensary
Dispensary District

You must select a dispensary to enter and purchase medical cannabis. The list of dispensaries currently licensed by the state of Illinois may be viewed at http://www.idfpr.com/Forms/MC/ListofLicensedDispensaries.pdf.

DESIGNATED CAREGIVER INFORMATION

The custodial parent or legal guardian shall serve as the designated caregiver and must complete the following information. A second caregiver may be identified by completing a caregiver application and payment of a caregiver registration fee.

Social Security Number (###-##-####)	Driver's License Number	Driver's License State	No Driver's License ❑
First Name	Middle Name	Last Name	
Home Address		Apartment or Suite Number	
City	County	State IL	ZIP Code
Telephone Number (###-###-####)	E-mail Address		
Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female		

SIGNATURE OF DESIGNATED CAREGIVER

DATE (mm/dd/yyyy)

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CERTIFICATIONS (To be completed by the designated caregiver)

I certify the information provided in this application is true and accurate to the best of my knowledge.

Submission of false, misleading or inaccurate information in connection with this application is grounds for revocation of my Illinois Medical Cannabis Qualifying Patient Registry Identification Card and other administrative, civil or criminal penalties.

I additionally certify that I have been given actual Notice and understand that, notwithstanding the Compassionate Use of Medical Cannabis Pilot Program Act (Act):

(i) cannabis is a prohibited Schedule I controlled substance under federal law;

(ii) participation in the program is permitted only to the extent provided by the strict requirements of the Act;

(iii) any activity not sanctioned by the Act may be a violation of state or federal law and could result in arrest, conviction, or incarceration;

(iv) growing, distributing, or possessing cannabis under the Act, unless done through a federally-approved research program, is a violation of federal law;

(v) growing, distributing, or possessing cannabis in any capacity, except through a federally-approved research program, may be a violation of state or federal law and could result in arrest, conviction or incarceration;

(vi) use of medical cannabis, or possessing a medical cannabis patient or caregiver registry card, may affect an individual's ability to receive or retain federal or state licensure in other areas;

(vii) use of medical cannabis or possessing a medical cannabis patient or caregiver registry card, in tandem with other conduct, may be a violation of state or federal law and could result in arrest, conviction or incarceration;

(viii) participation in the Medical Cannabis Pilot Program does not authorize any person to violate federal law or state law;

(ix) the Act does not provide any immunity from or affirmative defense to arrest or prosecution under federal law or state law, other than as set out in 410 ILCS 130/25; and

(x) applicants shall indemnify, hold harmless, and defend the state of Illinois for any and all civil or criminal penalties resulting from participation in the program.

DESIGNATED CAREGIVER SIGNATURE _____ DATE (mm/dd/yyyy) _____

APPLICATION FEES

Provide a check or money order payable to Illinois Department of Public Health.

Choose One:

Application Fee

- ☐ $100 – One-Year Registry Card
- ☐ $200 – Two-Year Registry Card
- ☐ $250 – Three-Year Registry Card

APPLICATION FEES ARE NOT REFUNDABLE

One caregiver is included in the application for a minor qualifying patient at no charge. A second caregiver may be added by completing a separate caregiver application and submitting the supporting documents and appropriate fee.

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Fingerprint Consent Form
Medical Cannabis Registry Identification Card

Pursuant to the Compassionate Use of Medical Cannabis Pilot Program Act, applicants for a Medical Cannabis Registry Identification Card must have a fingerprint-based criminal history record information background check. The Illinois Department of Public Health will comply with rules and regulations concerning your criminal background check authorized by the Compassionate Use of Medical Cannabis Pilot Program Act (410 ILCS 130), the UCIA (20 ILCS 2635) and applicable federal statute. This form captures the information required by licensed live scan fingerprint vendors to ensure your fingerprints are submitted properly. A transaction control number (TCN) will be issued by the live scan fingerprint vendor at the time of transmission of fingerprints. The TCN is verification your prints were taken and the vendor must fill in the TCN on this consent form. The live scan vendor will use the applicant information to help confirm your identification documentation before the fingerprints are taken. This document also serves as your consent form. The form must be signed in order to authorize the release of any criminal history record information that may exist. The results of the criminal history background check will be forwarded to the Illinois Department of Public Health for review.

Facility Information

Requesting Agency ORI Identifier:	Purpose Codes:
IL920709Z	❑ MMP Medical Marijuana Patient ❑ MMP Medical Marijuana Caregiver
Requesting Agency Name and Address: Illinois Department of Public Health, 535 West Jefferson Street, Springfield, Illinois, 62761-0001	
Contact Person Name: Division of Medical Cannabis	Contact E-mail and Phone #: DPH.MedicalCannabis@illinois.gov and 217-782-3300
Facility Cost Center (If any): *Note: Cost is responsibility of the applicant*	Transaction Control Number (TCN):

Applicant Information

Name:	Sex: Select	Race:	Date of Birth (mm/dd/yyyy):
SSN (optional):	Drivers License #:		Driver's License State:

Livescan Vendor/Appointment Information

Live Scan Fingerprint Vendor Name:	Address:	
Phone Number:	Appointment Date:	Appointment Time:

Privacy Statement

I, the undersigned, hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution, or entity having such information on file. I am aware and understand that my fingerprints may be retained and will be used to check the criminal history record information files of the Illinois State Police and/or the Federal Bureau of Investigation where permitted by law. I also understand that if my photo was taken, my photo may be shared only for employment or licensing purposes. I further understand that I have the right to challenge any information disseminated from these criminal justice agencies regarding me that may be inaccurate or incomplete pursuant to Title 28 Code of Federal Regulation 16.34 and Chapter 20 ILCS 2630/7 of the Criminal Identification Act.

Applicant Consent

Applicant Name (printed):	Date:
Applicant Name (signature):	Date:

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REQUIRED DOCUMENTS

Place the following items in an envelope and attach to fingerprint consent form:	
❑	**Non-refundable application fee (Check or Money Order to Illinois Department of Public Health)**
❑	**Photograph of Designated Caregiver** • Taken in the last 30 days • Taken against a plain, white or off-white background or backdrop • In natural color (Do not use a filter) • Full-face view directly facing the camera with a neutral facial expression and both eyes open • At least 2 inches by 2 inches in size It is recommended you use a passport photo vendor to ensure the photograph meets these requirements. Contact the Division of Medical Cannabis if a photograph is in violation of or contradictory to the qualifying patient's religious convictions.
Attach the following supporting documents to the fingerprint consent form:	
❑	**Proof of Designated Caregiver's Residency, Age, and Identity** Submit a clear, color copy of an Illinois Driver's License or Illinois State ID. If the address on your driver's license or ID does not match the address on your application, please submit one additional proof of residency.
❑	**Fingerprint receipt for Designated Caregiver** A listing of live scan fingerprint vendors can be found at https://www.idfpr.com/LicenseLookUp/fingerprintlist.asp. Contact the live scan fingerprint vendor before having fingerprints taken to make sure they take Medical Cannabis fingerprints. Remember to bring the fingerprint consent form to the vendor and add the Transaction Control Number (TCN) to your form. Once you have your fingerprints taken, the fingerprint consent form and the receipt provided by the live scan fingerprint vendor containing the TCN must be sent in with your application. Fingerprints must be taken within 30 days of submitting your application.
❑	**Copy of Minor Qualifying Patient's Birth Certificate**

Minor qualifying patients do not need to submit a photo or fingerprint background check.

Mail the application and required documents to:

Illinois Department of Public Health
Division of Medical Cannabis
535 West Jefferson Street
Springfield, Illinois 62761-0001

Questions? Contact the Division of Medical Cannabis at 855-636-3688 or DPH.MedicalCannabis@Illinois.gov.

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