San Joaquin County Public Health Services
health grows here

Medical Marijuana Identification Card - Requirement Checklist

IMPORTANT NOTE: Cards are valid for one year from date of issue and you will need to renew each year following the same process below.

Before Appointment:

You must complete the *Application/Renewal form* (CDPH 9042) and have your physician complete the *Written Documentation of Patient's Medical Records form* (CDPH 9044). After you gather all the required items listed below, please call the MMIC Office at (209) 468-3401 to schedule your IN-PERSON appointment.

You **must** bring the following items with you to your appointment or your application will be rejected:

- **MMIC Application/Renewal form** (CDPH 9042). Please make sure you read the application carefully and complete all necessary sections.
  - For applicants with a caregiver, the caregiver section must also be completed.
- **Written documentation from your physician** (CDPH 9044) recommending the use of medical marijuana as appropriate for one or more serious medical conditions (refer to CDPH 9044 for qualified conditions).
  - Must have original (wet/ink) signature. No fax, scan, e-mail copies will be accepted.
- **Proof of identity**. This can be a valid California Department of Motor Vehicles (DMV) driver's license or identification (ID) card, or another valid government-issued photo card.
  - For applicants with a caregiver, the caregiver must present their ID as well.
  - If you are under the age of 18 and lack photographic identification, you may substitute a certified copy of your birth certificate in place of the photo identification.
- **Proof of residency**. This can be a current and valid DMV motor vehicle registration, current rental or mortgage agreement, or utility bill. This proof must have patient's name bearing current physical address.
- **Fees**. Non-refundable application fee of $40.00 (or $20.00 for Medi-Cal beneficiaries).
  - Cash, Money Order, debit card, credit card accepted (no personal checks).
- **Medi-Cal Card** (*if applicable*)

During Appointment:

Documents will be reviewed. The MMIC Office is required to verify an applicant's medical documentation. It is the applicant's responsibility to ensure that the authorized medical release of information is on file with their medical provider. If your application for a MMIC is denied, you may file an appeal at no cost directly to the California Department of Public Health.

A photograph will be taken at your scheduled appointment for use on your ID Card. Fees will be collected and are non-refundable.

You will not get your ID card the same day as the appointment. It will be delivered to the MMIC Office, and we will call you when it arrives at our office. Turnaround varies; usually 1-2 weeks.

Additional Questions: Please call (209) 468-3401

Medical Marijuana Program
APPLICATION/RENEWAL
(Please Print)

Clear Form

This application is for (check one):

☐ Patient Only (Applicant) ☐ Primary Caregiver Only ☐ Patient and Primary Caregiver

SECTION 1 TO BE COMPLETED BY ALL APPLICANTS.

Patient Name (last, first, middle initial)			Date of birth (if less than 18 years of age)
Mailing address (number, street)			Telephone number
City	State	ZIP code	County of residence

Additional contact information

Is applicant under 18 years of age? ☐ Yes ☐ No

If yes, complete Section 2 for the parent, legal guardian, or person with legal authority to make medical decisions for minor applicant, unless minor applicant is *(check one)*:

☐ Lawfully emancipated; *or* ☐ Declares self-sufficient minor status or is a minor capable of medical consent

SECTION 2 TO BE COMPLETED FOR MINOR APPLICANT IDENTIFIED IN SECTION 1.

Parent/guardian/other name (last, first, middle initial)			Telephone number if different from above
Mailing address if different from above (number, street)	City	State	ZIP code

Relation to applicant *(check one)*:

☐ Parent with legal authority to make medical decisions
☐ Legal Guardian
☐ Other person or entity with legal authority to make medical decisions

SECTION 3 TO BE COMPLETED IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Does the applicant have the capacity to make medical decisions? ☐ Yes ☐ No

If "No," enter the name and address of person acting on the applicant's behalf:

Name (last, first, middle initial)			Telephone number
Mailing address (number, street)	City	State	ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

SECTION 4 TO BE COMPLETED BY THE PRIMARY CAREGIVER REQUESTING AN IDENTIFICATION CARD.

Name (last, first, middle initial)			Date of birth (if less than 18 years of age)
Mailing address (number, street)			Telephone number
City	State	ZIP code	County of residence

Primary Caregiver Duties: *(Document how you consistently assume responsibility for the housing, health, or safety of the applicant.)*

Check your designation as a primary caregiver from the following list:

- ☐ I am the parent of the applicant or the person entitled to make medical decisions on behalf of the applicant.
- ☐ I am the designated primary caregiver for only this applicant.
- ☐ I am the designated primary caregiver for another applicant (qualified patient) in this county.
- ☐ I am the designated primary caregiver for an applicant (qualified patient) in a different county.

County name: _____

Check one of the two following choices if your status as a primary caregiver is linked to a health related entity:

- ☐ I am the owner/operator of a clinic pursuant to Chapter 1 (commencing with Section 1200), Division 2 of the Health and Safety (H&S) Code.
- ☐ I am a clinic/facility/hospice or home health agency employee* designated by the owner/operator to serve as a primary caregiver.

Check all that apply:

- ☐ This health care facility is licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the H&S Code.
- ☐ This residential care facility is licensed pursuant to Chapter 3.01 (commencing with Section 1568.01), Division 2 of the H&S Code.
- ☐ This residential care facility is licensed pursuant to Chapter 3.2 (commencing with Section 1569), Division 2 of the H&S Code.
- ☐ This hospice or home health agency is licensed pursuant to Chapter 8 (commencing with Section 1725), Division 2 of the H&S Code.

* Health and Safety Code, Section 11362.7(d)(1), limits a maximum of three employees that may serve as primary caregivers. **Note:** Include a copy of this page for each caregiver.

Primary Caregiver Declaration: I understand and acknowledge my assigned duties as the designated primary caregiver for

_____. I understand that if the applicant's identification card expires, then my primary caregiver
Applicant's name

identification card shall also expire. I agree to return my primary caregiver identification card to this county health department or its designee if this applicant changes primary caregivers. I agree that if I am the owner or operator of a health care facility designated as the primary caregiver of this applicant, that I shall notify this county health department or its designee if a change of primary caregivers is made. I declare under penalty of perjury that the information I provided on this form is true and correct.

_____
Printed name of primary caregiver

_____ _____
Signature of primary caregiver Date

SECTION 5 **ALL APPLICANTS MUST IDENTIFY THEIR ATTENDING PHYSICIAN.**

Attending physician name			California medical license number
Service mailing address (number, street)			Licensed by *(check one)*
			☐ California Board of Podiatric Medicine ☐ Medical Board of California Osteopathic ☐ Medical Board of California
City	State	ZIP code	
Office telephone number		Office fax number	

The Civil Code, Section 1798.17, requires that this notice be provided when collecting personal or confidential information from individuals. Providing the individual information and identifying information requested on this form is mandatory. Failure to furnish this information to the administering agency, in order to process your application for a medical marijuana identification card, will result in denial of your application. The information collected will be verified for accuracy to determine eligibility for a medical marijuana identification card. Sections 11362.71 and 11362.715 of the Health and Safety Code authorize the collection and maintenance of the information.

The Compassionate Use Act of 1996 (Act) (Health & Safety Code, Section 11362.5) ensures that patients and their primary caregivers who possess or cultivate marijuana for the personal medical purposes of the patient upon the recommendation of a physician are not subject to California criminal prosecution or sanction. However, the Act does not protect marijuana plants from seizure nor individuals from federal prosecution under the federal Controlled Substances Act. The information that you provide in this application may be released as required by law, judicial order, or subpoena, and could be used in a federal criminal prosecution.

You have the right to access records containing your personal information which are maintained by the county health department, or the county's designee, and the California Department of Public Health.

Responsibilities

It is my responsibility:

- To notify, within seven days, the county health department or the county's designee of any changes in my attending physician or designated primary caregiver.
- To use my identification card only for the purposes intended by the law.
- To ensure that an authorized medical release of information is on file with my medical provider in order to complete my application.

Declaration

I have read the notice required by Civil Code, Section 1798.17 and understand my responsibilities as stated above concerning my participation in the Medical Marijuana Program. I confirm to the best of my knowledge the listed duties and information provided by my primary caregiver. I declare under penalty of perjury that the information I provided on and with this application is true and correct.

Print name of applicant or legal representative

Signature of applicant or legal representative

Date

Medical Marijuana Program
WRITTEN DOCUMENTATION OF PATIENT'S MEDICAL RECORDS
(Please Print)

Note to Attending Physician: This form will serve as written documentation from the attending physician, stating that the patient has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate. A copy of this form must be filed in the attending physician's medical records for the patient. If the patient chooses to apply for a Medical Marijuana Identification card through the county health department or its designee, the agency will call the attending physician to verify the information contained on this form, in accordance with Health & Safety Code, Section11362.72 (a)(3).

Attending physician name			California medical license number
Service mailing address (number, street)			Office telephone number
City	State	ZIP code	Office fax number

Licensed by *(check one)*:

☐ Medical Board of California ☐ Osteopathic Medical Board of California ☐ California Board of Podiatric Medicine

_____ is a patient under the medical care and supervision of the above
Patient's name

named physician who has diagnosed the patient with one or more of the following medical conditions:

1. Acquired Immune Deficiency Syndrome (AIDS)
2. Anorexia
3. Arthritis
4. Cachexia
5. Cancer
6. Chronic pain
7. Glaucoma
8. Migraine
9. Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis
10. Seizures, including, but not limited to, seizures associated with epilepsy
11. Severe nausea
12. Any other chronic or persistent medical symptom that either:
    a. Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990.
    b. If not alleviated, may cause serious harm to the patient's safety or physical or mental health

ATTENDING PHYSICIAN STATEMENT:

This patient has been diagnosed with one or more of the foregoing medical conditions and the use of medical marijuana is appropriate.

_____ _____ _____
Attending physician's signature Telephone number Date

Original—Patient Copy—Patient's File