



**Alcoholic Beverage Regulation Administration  
Medical Cannabis  
PATIENT APPLICATION**

*Please refer to the Application Instructions when completing this form. Type or block print only. Do not use felt-tip pen.*

<b>Patient Name</b>  <input type="checkbox"/> <b>Initial</b>  <input type="checkbox"/> <b>Renewal</b>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>First Name</span><span>Middle Initial</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>Last Name</span><span>Suffix (i.e., Jr., Sr., II, III)</span></div>
<b>Social Security Number</b>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="text-align: right; font-size: small;">*if applicant does not have a Social Security Number, see application instructions</div>
<b>Date of Birth</b>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="text-align: right; font-size: small;">*If patient is under 18, use Minor Patient application</div> <div style="display: flex; justify-content: space-between;"><span>Month</span><span>Day</span><span>Year</span></div>
<b>Mailing Address</b> It is your responsibility to notify ABRA of all address changes	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>Street (P.O. Box NOT acceptable)</span><span>Apt/Suite</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>City</span><span>State</span><span>Zip Code</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>( ) Phone Number</span><span>Email Address</span></div>
<b>Healthcare Practitioner Name and Office Address Information</b>  <b>Select one:</b>  <input type="checkbox"/> <b>Physician (MD, DO)</b>  <input type="checkbox"/> <b>Nurse Practitioner/ APRN</b>  <input type="checkbox"/> <b>Physician Assistant (PA)</b>  <input type="checkbox"/> <b>Naturopathic Physician</b>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>First Name</span><span>Middle Initial</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>Last Name</span><span>Suffix (i.e., Jr., Sr., II, III)</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>Street (P.O. Box NOT acceptable)</span><span>Apt/Suite</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>City</span><span>State</span><span>Zip Code</span></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"><span>( ) Phone Number</span><span>Email Address</span></div>



<p><b>Application checklist</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Two recent (2) Passport photos (2"x2")</li> <li><input type="checkbox"/> Photocopy of U.S., State, or District government-issued photo ID</li> <li><input type="checkbox"/> Application fee (paid by certified check, money order or cashier's check payable to DC Treasurer)</li> <li><input type="checkbox"/> \$25.00 (Submit proof of low income)</li> <li><input type="checkbox"/> \$100.00</li> <li><input type="checkbox"/> Two (2) forms of proof of residency</li> <li><input type="checkbox"/> Electronic Healthcare Practitioner Recommendation</li> </ul>
<p><b>Patient's Attestation Signature and Date</b></p>	<p><b>Limitation of Liability</b> – The District of Columbia shall not be liable to the registrant, its employees, agents, business invitees, licensees, customers, clients, family members or guests for any damage, injury, accident, loss, compensation or claim, based on, arising out of or resulting from registrant's participation in the District of Columbia's medical cannabis program, including but not limited to the following: arrest and seizure of persons and/or property, prosecution pursuant to federal laws by federal prosecutors, interruption in registrant's ability to operate its medical cannabis cultivation center and/or dispensary; any fire, robbery, theft, mysterious disappearance or any other casualty; the actions of any other registrants or persons within the cultivation center and/or dispensary. This Limitation of Liability provision shall survive expiration or the earlier termination of this registration if such registration is granted.</p> <p><b>Federal Prosecution</b> - The United States Congress has determined that cannabis is a controlled substance and has placed cannabis in Schedule I of the Controlled Substance Act. Growing, distributing, and possessing cannabis in any capacity, other than as a part of a federally authorized research program, is a violation of federal laws. The District of Columbia's law authorizing the District's medical cannabis program will not excuse any registrant from any violation of the federal laws governing cannabis or authorize any registrant to violate federal laws.</p> <p>I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge. I acknowledge receipt and advisement of the notices above, and I agree to and accept the limitation of liability against the District. I assume any and all risk or liability that may result under the District of Columbia or federal laws arising from the possession, use, or cultivation, administration, or dispensing of medical cannabis. I understand that the medical cannabis laws and enforcement thereof of the District of Columbia and the federal government are subject to change at any time. I sign this attestation willingly and without reservation and am fully aware of its meaning and effect.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%;"> <p>_____</p> <p>Patient's Signature</p> </div> <div style="width: 35%;"> <p>_____</p> <p>Date</p> </div> </div> <p style="text-align: center; margin-top: 20px;"><b>All fees are non-refundable</b></p>



## **Alcoholic Beverage Regulation Administration Medical Cannabis PATIENT APPLICATION**

### **APPLICATION INSTRUCTIONS**

To apply for a patient registration identification card, applicants shall submit a complete application to the Alcoholic Beverage Regulation Administration (ABRA) on the required form, which shall include:

- Completed and signed Patient Application Form, OR completed and submitted online electronic Patient Application (on ABRA's website).
- Two (2) recent Passport-type photographs: two (2) photographs of the applicant's face measuring two inches by two inches (2" x 2"), which clearly exposes the area from the top of the forehead to the bottom of the chin.
- Clear photocopy of a U.S., state, or District government-issued photo ID as proof of identity.
- Caregiver Application Form (optional). Note: *required if applying for minor patient*
- Proof of District Residency (*for residency requirements, see page 3*)
- Electronic Healthcare Practitioner Recommendation Form
  - Must be dated no longer than ninety (90) days prior to the application date
- Payment of the Application Fee

Mail your completed application and payment to:

**ALCOHOLIC BEVERAGE  
REGULATION ADMINISTRATION  
2000 14th Street, N.W. 4th Floor  
Washington, DC 20009**

#### **Minors**

If patient is under 18, please use the Minor Patient application online.

#### **Social Security Number**

If an applicant does not have a Social Security number:

- (1) Submit with the application a sworn affidavit, under penalty of perjury, stating that the Applicant does not have a Social Security number
- (2) Provide the Alcoholic Beverage Regulation Administration with Social Security information once a Social Security number has been obtained



## **REGISTRATION FEES**

All registration and permit fees must be paid by certified check, money order, or cashier's check payable to the **DC Treasurer**. Fees must be paid at the time an application is submitted.

### **The registration, renewal and replacement fees are as follows:**

- Initial registration fee \$100.00
- Renewal fee \$100.00
- Replacement card fee \$90.00

### **Reduced Fees**

The initial registration fees for a qualifying patient or caregiver whose income is *equal to or less than two hundred percent (200%) of the federal poverty level* will be twenty-five percent (25%) of the published standard qualifying patient or caregiver registration fee as follows:

- Initial registration fee \$25.00
- Renewal fee \$25.00
- Replacement card fee \$20.00

### **In verifying income for reduced fees, applicants must supply proof of the following:**

- Proof of being a current Medicaid or DC Alliance recipient; or
- Documentation verifying that the applicant's total gross income, including child support payments, alimony and rent payments received and any other income received on a regular basis, is equal to or less than 200% of the federal poverty level, as defined by the US Department of Health and Human Services.

In verifying income for the purposes of this qualification, an individual may submit the following:

- Earnings statements received within the previous thirty (30) days
  - District of Columbia or federal tax filing returns for the most recent tax year;
  - For newly employed applicants, a verifiable copy of an offer of employment that states the amount of salary to be paid;
  - A copy of a Social Security or worker's compensation benefit statement;
  - Proof of child support or alimony received;
  - Any other unearned income or assets including, but not limited to, stocks, bonds, annuities, private pension and retirement accounts; or
- Any other item(s) of proof deemed by the Alcoholic Beverage Regulation Administration or the Alcohol Beverage Control Board or their designated agent reasonably calculated to demonstrate a person's current income.

Applicants must submit the required verifying information for each renewal or request for a replacement card in order to receive the reduced fee.



## **PROOF OF RESIDENCY**

In order to qualify for the Medical Cannabis Program, you must be a resident of the District of Columbia. For purposes of this requirement, a patient shall be a resident of the District of Columbia if the individual: (a) is physically present in the District of Columbia; (b) has taken verifiable actions to make the District his or her home indefinitely with no present intent to reside elsewhere; and (c) is not merely present in the District for the sole purpose of obtaining medical cannabis.

To prove District of Columbia residency, applicants must submit at least **TWO (2)** of the following items in the name of the applicant. Check two forms of proof of residency from the list below and attach the according documents to the application.

- \_\_\_ Proof of payment of District of Columbia personal income tax, in the name of the applicant, for the tax period closest in time to the application date
- \_\_\_ A property deed for a District of Columbia residence showing the applicant as an owner or co- owner
- \_\_\_ A valid unexpired lease or rental agreement in the name of the applicant on a District of Columbia residential property
- \_\_\_ A pay stub issued less than forty-five (45) days prior to the application date which shows evidence of the applicant's withholding of District income tax
- \_\_\_ A voter registration card with an address in the District of Columbia
- \_\_\_ Current official documentation of financial assistance received from the District Government including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income (SSI), housing assistance, or other governmental programs
- \_\_\_ A current motor vehicle registration in the name of the applicant evidencing District residency
- \_\_\_ A valid unexpired District motor vehicle operator's permit or other official non-driver identification in the name of the applicant
- \_\_\_ A utility bill (excluding telephone bill) from a period within the two (2) months immediately preceding the application date in the name of the applicant on a District of Columbia residential address
- \_\_\_ Any other reasonable form of verification deemed by the Alcoholic Beverage Regulation Administration or the Alcohol Beverage Control Board or their designated agent to demonstrate proof of current residency