

**NEW APPLICATION FORM**  
**Registration for the Montana Medical Marijuana Program**

Instructions: **Please complete all information to comply with the registration requirements of the Montana Medical Marijuana Act.** If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver and the information requested on the back of this form must be completed. List your current Montana Drivers License number **or** your Montana State Identification Card number if applicable **and** your Social Security Number. Please type or print legibly.

**QUALIFYING PATIENT INFORMATION (REQUIRED)**

NAME (LAST, FIRST, M.I.): \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_

DATE OF BIRTH: \_\_\_\_\_ MT DRIVERS LICENSE OR MT STATE ID # \_\_\_\_\_ SSN \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ COUNTY \_\_\_\_\_ PHONE # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
(OPTIONAL)

**CAREGIVER (IF APPLICABLE)**

NAME (LAST, FIRST, M.I.): \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_

DATE OF BIRTH: \_\_\_\_\_ MT DRIVERS LICENSE OR MT STATE ID # \_\_\_\_\_ SSN \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ COUNTY \_\_\_\_\_ PHONE # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
(OPTIONAL)

**NEW REGISTRATION FEE (REQUIRED)**

**The registration fee for a NEW application is \$50.00 and is non refundable unless the applicant is denied.**  
Enclose your check or money order made payable to "DPHHS /LICENSURE BUREAU"

**SIGNATURE & DATE REQUIRED**

QUALIFYING PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
**"QUALIFYING PATIENT" Means a person who has been diagnosed by a physician as having a Debilitating Medical Condition.**

CAREGIVER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
**As the CAREGIVER for the Qualifying Patient named above, I agree to provide Medical Marijuana only to this Qualifying Patient. I have never been convicted of a felony drug offense. I understand that I am subject to a mandatory background check.**

**(OVER)**

## DECLARATION OF PERSON RESPONSIBLE FOR MINOR

**INSTRUCTIONS: Complete all information in order to comply with the registration requirements of the Montana Medical Marijuana Act. This portion is required in addition to the patient application portion if the qualifying patient is under 18 years of age.**

1. I am the \_\_\_Custodial Parent or \_\_\_Legal Guardian with responsibility for health care decisions for:

\_\_\_\_\_  
MINORS NAME

2. The applicant's attending physician has explained to the minor and me the potential risk and benefits of the medical use of marijuana.
3. I consent to the use of marijuana by the applicant for medical purposes.
4. I agree to serve as minor's designated primary caregiver; AND
5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the minor.

NAME (LAST, FIRST, M.I.): \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MT DRIVERS LICENSE OR STATE ID # \_\_\_\_\_ SSN \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
(optional)

**SIGNATURE OF CUSTODIAL PARENT OR LEGAL GUARDIAN:** \_\_\_\_\_

MAIL APPLICATION FORM TO: DPHHS / QUALITY ASSURANCE DIVISION  
LICENSURE BUREAU  
PO BOX 202953  
HELENA MT 59620-2953