State of Illinois
Illinois Department of Public Health

QP

Illinois Medical Cannabis Pilot Program

Application for Qualifying Patient Registry Identification Card Instructions

Applicants should discuss the use of medical cannabis with their physician prior to beginning an application. All applicants, except for Veterans receiving care at a VA facility, must have their physician submit a written certification for the use of medical cannabis.

To qualify for a patient registry identification card, a qualifying patient must:

- Be a resident of the State of Illinois at the time of application and remain a resident during participation in the program;
- Have a qualifying debilitating medical condition;
- Have a signed physician certification;
- Be at least 18 years of age;
- Not hold a school bus permit or Commercial Driver's License; and
- Not be an active duty law enforcement officer, correctional officer, correctional probation officer, or firefighter.

Physician Written Certification

Ask your physician to complete the Physician Written Certification Form and return it to you to include it with your application. You must see your physician no more than 90 days before you submit your application.

Physician Written Certification for Veterans receiving care at a U.S. Department of Veterans Affairs (VA) Facility

Veterans receiving health care at a VA facility do not need to provide a physician written certification, but must instead provide medical records from the VA facility for the last 12 months.

- Use VA form 10-5345 to request these records (U.S. Department of Veterans Affairs, Request for and Authorization to Release Medical Records and Health Information). *If you have received care for your debilitating medical condition for more than 5 years at a VA facility, you must mark "OTHER" on VA Form 10-5345 under "Information Requested" then write that you are requesting information about the treatment of your qualified condition for the most recent 12-month period. Under "PURPOSE(S) OR NEED FOR WHICH THE INFORMATION TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED" write "Personal Medical Purposes". Under "NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED" write your address. The records will be sent to you.*
- To obtain VA medical records electronically, go online to https://www.myhealth.va.gov/index.html
- Once you receive your official medical records, **you must submit the medical records with your application**.

Mail the application and the required documents to:

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

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*****Do not use this form for Terminal Illness*****

QUALIFYING PATIENT INFORMATION

Social Security Number (###-##-####)	Driver's License/State ID Card Number	Driver's License/State ID Card 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		
Are you an active duty law enforcement officer, correctional officer, correctional probation officer or firefighter? ❑ Yes ❑ No	Do you have a school bus permit or a Commercial Driver's License? ❑ Yes ❑ No		

PHYSICIAN INFORMATION

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

MEDICAL CANNABIS DISPENSARY SELECTION

Name and Address of Dispensary
PDI Medical 1623 Barclay Blvd, Buffalo Grove, IL. 60089
Dispensary District
27-002

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.

This application was prepared by:

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

FIRM OR ORGANIZATION NAME _____ PHONE NUMBER _____

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Illinois Medical Cannabis Pilot Program

Application for Registry Identification Card for Qualifying Patients

CERTIFICATIONS

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.

SIGNATURE OF QUALIFYING PATIENT _____ DATE (mm/dd/yyyy) _____

APPLICATION FEES

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

Choose One:

Application Fee	Reduced Application Fee*
❑ $100 – One-Year Registry Card	❑ $50 – One-Year Registry Card
❑ $200 – Two-Year Registry Card	❑ $100 – Two-Year Registry Card
❑ $250 – Three-Year Registry Card	❑ $125 – Three-Year Registry Card

*The reduced fee is for qualifying patients enrolled in the Federal Social Security Disability Income (SSDI), Supplemental Security Income (SSI) disability programs, or Veterans.

Patients enrolled in SSDI or SSI – Submit a "Benefit Verification Letter" from the Social Security Administration that shows your name and address and the type of benefits that are received. This letter must be dated within the last year. You can get this letter by using your My Social Security account online at https://www.ssa.gov/myaccount/ or calling the Social Security Administration at 1-800-772-1213. Annual cost of living increase letters will not be accepted as proof because they do not show the type of benefits received.

Veterans – Submit a copy of your DD-214 showing dates of service and character of service (type of discharge).

APPLICATION FEES ARE NOT REFUNDABLE

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REQUIRED DOCUMENTS

	Place the following items in an envelope:
❑	**Non-refundable application fee (Check or Money Order to Illinois Department of Public Health)**
❑	**Photograph** • 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 age and identity** Submit a clear, color copy of an Illinois Driver's License, Illinois State ID, or the photograph page of a US passport.
❑	**Proof of residency** If your Driver's License, Temporary Visitor Driver's License or State ID address matches your application submit **one** additional proof of residency. If you submit a US Passport as your proof of identity or your Driver's License or State ID address does not match the address on your application, submit two of the following: • Pay stub or electronic deposit receipt, issued less than 60 days prior to the application date, that shows evidence of withholding for State income tax • Valid voter registration card with an address in Illinois • Current military identification card; • Bank statement (dated less than 90 days prior to application) or credit card statement (dated less than 60 days prior to application); • Deed/title, mortgage or rental/lease agreement; property tax bill; • Insurance policy (current coverage for automobile, homeowner's, health or medical, or renter's); • Medical claim or statement of benefits (from a hospital or health clinic, private insurance company or public (government) agency, dated less than 12 months prior to application) • Tuition invoice/official mail from college or university, dated less than the 12 months prior to application • Utility bill, including, but not limited to, those for electric, water, refuse, telephone land-line, cellular phone, cable or gas, issued less than 60 days prior to application • W-2 from the most recent tax year Proof of residency must include name and address and match the address on the application
❑	**Benefit Verification Letter from the Social Security Administration or DD-214 (if applicable)**

Mail the application and required documents to:

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

DO YOU NEED A CAREGIVER? If you need someone to go to a dispensary for you or with you, that person must have a registry card.
Complete the Designated Caregiver Application and submit the required documents with your patient application.

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

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