PEDIATRIC MEDICAL MARIJUANA PATIENT APPLICATION

Mail Completed Application to: Office of the Marijuana Commissioner ATTN: MMP 1128 South Bradford Street Dover, DE 19904	☐ New Pediatric Patient	☐ Renewing Pediatric Patient
	Application Fee Includes parent/guardian fees	1 year 2 year 3 year $50 $75 $100

Print clearly. Incomplete applications may be denied. Application fees are non-refundable. ***Faxed copies of applications will not be accepted***.

PEDIATRIC (AGE 17 OR YOUNGER) PATIENT INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F ☐ X	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		

PRIMARY PARENT/GUARDIAN INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F ☐ X	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Relationship to Applicant:		☐ Check this box if confidential information may be shared by email.
Email Address: ***(Optional)***		

SECONDARY PARENT/GUARDIAN INFORMATION (OPTIONAL – ONLY IF SECOND CAREGIVER CARD REQUIRED)

Name: *(Last, First, M.I.)*	☐ M ☐ F ☐ X	**Date of Birth:**
Address: *(Street)*		
Address: *(City, State, ZIP Code)*		
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Email Address: *(Optional)*		☐ Check this box if confidential information may be shared by email.
Relationship to Applicant:		

PARENT/GUARDIAN'S ATTESTATION STATEMENT

By signing below, the parent/guardian(s) certifies that the information on this application is complete, true, and submitted for the purpose of obtaining a State of Delaware Pediatric Medical Marijuana Patient Registry Card. If approved for the Registry Card, the parent/guardian acknowledges receipt of and agrees to the terms of the Delaware Medical Marijuana Act, Title 16 of the Delaware Code, Chapter 49A on behalf of the Pediatric Patient.

_____ *initial*	I hereby certify that all the information provided on this application is true and accurate to the best of my knowledge.
_____ *initial*	I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided.
_____ *initial*	I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.

_____ Parent/Guardian Signature	_____ Date of Signature
_____ Parent/Guardian Signature	_____ Date of Signature

APPLICATION CHECKLIST

☐	**Did both guardians initial all three of the Attestation Statements and sign on the signature line?**
☐	**Did you include the signed Health Care Practitioner Certification form?**
☐	**Did both guardians include a legible copy of their Delaware driver's license or state-issued identification?**
☐	**Did you include the non-refundable application fee? Please make check or money order payable to State of Delaware.**

PEDIATRIC HEALTH CARE PRACTITIONER CERTIFICATION

PATIENT'S INSTRUCTIONS: The patient's pediatric specialty Health Care Practitioner will complete this entire section. Only a pediatric neurologist, a pediatric gastroenterologist, a pediatric oncologist, or a pediatric palliative are specialist can certify for patients aged 17 and under.

This section should be submitted with your completed application to the Medical Marijuana Program – partial applications will not be accepted. **The patient application must be received by the Medical Marijuana Program, within 90 days of the Health Care Practitioner's signature date.**

Faxed and electronic copies will not be accepted.

PEDIATRIC HEALTH CARE PRACTITIONER INFORMATION (MUST BE A PEDIATRIC NEUROLOGIST, PEDIATRIC GASTROENTEROLOGIST, PEDIATRIC ONCOLOGIST, PEDIATRIC PALLIATIVE CARE SPECIALIST, PEDIATRIC PSYCHIATRIST, OR A DEVELOPMENTAL PEDIATRICIAN)

Name: *(Title, First, MI, Last, Suffix)*		**Medical License Number:**
Address: *(Street, Building, Suite #)*		**License State:** *(Must be licensed in Delaware)*
Address: *(City, State, ZIP Code)*		**License Type:** *(MD, DO, APN, PA)*
Pediatric Specialty:		
Phone:	**Fax:**	**Email:** *(not required)*

Health Care Practitioner Identified Medical Condition(s) for Pediatric Patients:

Health Care Practitioner's Signature (no signature stamps accepted)	Date