Arizona Department of Health Services

Medical Marijuana Program
Qualifying Patient Checklist

Please note that this checklist information and other instructions may change. Please refer back to the ADHS website for the most current information.

Print out and review this checklist **prior to** submitting your Qualifying Patient Application in the ADHS online system. This checklist will assist you in compiling the required information and supporting documentation. Application requirements are also outlined in Arizona Administrative Code (A.A.C.) R9-17-202.

You will be asked to enter the following information and submit the following supporting documents:

1. Application Information:
□ The patient's □ First name; middle initial, if applicable; last name; and suffix, if applicable □ Date of birth □ Gender
□ The identifying number on the applicable card or document (see Section 2 below for list of identification requirements and options). The patient must also enter the ID type, issuing state, and issued date.
□ The patient's residential address and county.
□ The patient's phone number.
□ The patient's email address where confidential information can be sent (free email address website links are provided within the application).
□ The patient's mailing address. Patient can check box if same as residential address.
□ The name, address, and telephone number of the physician attesting for the patient. This information must be obtained from the *Medical Marijuana Physician Certification* form.
□ The physician's license number, physician license state, and license type. This must be obtained from the *Medical Marijuana Physician Certification* form.
□ The patient's Qualifying Health Conditions that apply. This information must be obtained from the *Medical Marijuana Physician Certification* form.
□ If the patient is designating a caregiver, the following **caregiver** information: □ First name; middle initial, if applicable; last name; and suffix, if applicable □ Date of birth □ Gender □ Address and county where caregiver resides
□ Whether the patient is requesting authorization to cultivate marijuana plants.
□ If the patient designated a caregiver, if the caregiver is requesting to cultivate marijuana plants.
□ Whether the patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana.
□ If the patient is eligible for the Supplemental Nutrition Assistance Program (SNAP), documentation required.
□ If the patient is homeless, an address where the patient can receive mail.
2. Documentation Needed for Uploading • **The current photograph must be an image file (JPG, PNG, or GIF file format) and cannot exceed 10 MB.** • **The other supporting documents can be PDF documents or image files (JPG, PNG, or GIF file format) and cannot exceed 2 MB. The recommended file type is PDF.**
□ A current photograph of the patient. Photograph must be taken no more than 60 calendar days before the submission of the application. Photograph must be capable of producing an image:

- 2 inches by 2 inches in size with minimum dimensions of 600x600 pixels and maximum dimensions of 1200x1200 pixels.
- In natural color
- That is a front view of the individual's full face, without a hat or headgear that obscures the hair or hairline, with a plain white or off-white background
- That has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head

□ A copy of the patient's:
- □ Arizona driver's license issued on or after October 1, 1996; **OR**
- □ Arizona identification card issued on or after October 1, 1996; **OR**
- □ Arizona registry identification card; **OR**
- □ Photograph page in the patient's U.S. passport; **OR**
- □ An Arizona driver's license or identification card issued before October 1, 1996 **AND** one of the following:
  - □ Birth certificate verifying U.S. citizenship
  - □ U.S. Certificate of Naturalization
  - □ U.S. Certificate of Citizenship

□ Signed and dated *Medical Marijuana Patient Attestation*. This must be downloaded from the ADHS website at http://www.azdhs.gov/medicalmarijuana/patients/adult.htm.

□ Physician-completed *Medical Marijuana Physician Certification Form*. This must be downloaded from the ADHS website at http://www.azdhs.gov/medicalmarijuana/physicians/.

□ SNAP documentation (if applicable): a copy of an eligibility notice or an electronic benefits transfer card demonstrating current participation in the U.S. Department of Agriculture Food and Nutrition Services, Supplemental Nutrition Assistance Program.

□ A valid and current Visa or MasterCard for payment. A credit card, debit card, or pre-paid cards are accepted.

Arizona Department of Health Services

Medical Marijuana Program
Qualifying Patient Application Information

Please note that application information and other instructions may change. Please refer back to the ADHS website for the most current information.

Please read this information before beginning the application process.

1. Print and review the Qualifying Patient Checklist. This checklist will assist you in compiling the required information and supporting documentation in order to complete the online application process.
2. Visit the ADHS Medical Marijuana Frequently Asked Questions (FAQs) webpage for more detailed information and specifics regarding qualifying patients. http://www.azdhs.gov/medicalmarijuana/faqs/
3. Print the *Medical Marijuana Physician Certification* form from the ADHS website http://www.azdhs.gov/medicalmarijuana/physicians/. This form must be downloaded, taken to your physician, and completed. If there are any areas that are not completed, ADHS will not accept the application. You **must** use this form for your application; no other forms will be accepted.
4. Print, sign, and date the *Medical Marijuana Patient Attestation*. This form must be downloaded from the ADHS website at http://www.azdhs.gov/medicalmarijuana/patients/adult.htm
5. Before you begin your online application, you will need specific images and other documents (including those listed in #3 and #4 above) that must be uploaded with your application. The required documents and formatting instructions are listed in the Qualifying Patient Checklist.
6. Once all information and documentation from the Qualifying Patient Checklist has been obtained and properly formatted, you may begin the online application. Ensure all information is completed. After completing the fields, you will be prompted to upload the required documentation.
7. You will need a MasterCard or Visa to pay your application fee. A credit card, debit card, or pre-paid cards are accepted. Please note that application fees are non-refundable.
8. Once you have successfully paid the application fee, press "Continue" to return to the ADHS online system to print out your completed application. You should retain your application so it is accessible to you. You will need the application number and submission date for the system to find your application in the future.
9. Once successfully submitted through the ADHS online system, ADHS will review your application. If approved, you will receive an automatically-generated email indicating your approval. If more information is needed or the application has deficiencies, you will be notified and provided with further instructions on how to correct and resubmit your application.
10. Upon approval, your registry identification card will be mailed to you at the address you provided in the application.

***Designating a Caregiver**

If you have designated a caregiver within the ADHS online system, your caregiver must also apply. Your patient application must be completed and approved before your designated caregiver can apply through the ADHS online system. Your caregiver will need your Patient Application ID #, your full name and date of birth in order to begin the application process. Please note that your caregiver must also submit fingerprints to ADHS through the U.S. Mail as part of his or her application. Please direct your caregiver to the appropriate section on the ADHS website for more information: http://www.azdhs.gov/medicalmarijuana/caregivers/.

Print Form

ARIZONA DEPARTMENT OF HEALTH SERVICES
MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA PATIENT ATTESTATION

I, _____, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

MEDICAL MARIJUANA PHYSICIAN CERTIFICATION

PHYSICIAN INFORMATION

FOR ALL QUALIFYING PATIENTS

Physician's Name:	
Arizona License Number:	Type: ☐ MD ☐ DO ☐ NMD/ND ☐ MD(H)/DO(H)

PHYSICIAN INFORMATION ON FILE WITH LICENSING BOARD

Office Address:	
Telephone Number:	Email Address:

QUALIFYING PATIENT INFORMATION

Patient's Name:	Date of Birth:

CHECK ONE OR MORE BOXES TO INDICATE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION

☐ Acquired immune deficiency syndrome (AIDS)	☐ Agitation of Alzheimer's disease
☐ Amyotrophic lateral sclerosis (ALS)	☐ Cancer
☐ Crohn's disease	☐ Glaucoma
☐ Human immunodeficiency virus (HIV)	☐ Hepatitis C

IF A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION OR THE TREATMENT FOR A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION CAUSES:

☐ Cachexia or wasting syndrome	☐ Severe and chronic pain
☐ Severe nausea	☐ Seizures, including those characteristic of epilepsy

☐ Severe or persistent muscle spasms, including those characteristic of multiple sclerosis

IF ANY CONDITION ABOVE IS CHECKED, INDICATE THE UNDERLYING CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION:

I, _____, THE PHYSICIAN:

- Have made or confirmed a diagnosis of a debilitating medical condition, as defined in A.R.S. § 36-2801, for the qualifying patient.

  Initial: _____

- Have established a medical record for the qualifying patient and am maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297.

  Initial: _____

- Have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days appropriate to the qualifying patient's presenting symptoms and the debilitating medical condition I diagnosed or confirmed.

  Date of Examination: _____ Initial: _____

- Have reviewed the qualifying patient's medical records, including medical records from other treating physicians from the previous 12 months, the qualifying patient's responses to conventional medications and medical therapies, and the qualifying patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database.

  Initial: _____

- Have explained the potential risks and benefits of the medical use of marijuana to the qualifying patient or, if applicable, the qualifying patient's custodial parent or legal guardian.

  Initial: _____

- Have referred the qualifying patient to a dispensary. YES ☐ NO ☐ If YES, I have disclosed to the qualifying patient or, if applicable, the qualifying patient's custodial parent or legal guardian any personal or professional relationship I have with the dispensary.

  Initial: _____

PHYSICIAN'S ATTESTATION

I,_____ , in my professional opinion believe that the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition. I attest that the information provided in this written certification is true and correct.

_____ _____

Physician's Signature Date Signed