IOWA | Health and Human Services
Division of Compliance

Medical Cannabis Registration Card
Adult Patient Application

- For adult patients with a designated primary caregiver, the caregiver must also complete the Primary Caregiver Application.
- For patients under 18 years old (minors), use the Primary Caregiver Application, and do not complete this Adult Patient Application.

Online submission is preferred and will result in quicker review and approval.
For online submission of registration applications, visit:
https://hhs.iowa.gov/medical-cannabis.

Print clearly. Incomplete applications may be denied. Application fees are non-refundable.

Patient Information	
Name (First, Middle, Last)	
Sex ☐ Male ☐ Female ☐ Unknown	
Date of Birth (must be 18 or older)	
Driver's License or Nonoperator's ID Number	
Permanent Address (Street, Apt. #)	
Address (City, State, Zip Code)	
Mailing Address (if different than above) (Street, Apt. #)	
Mailing Address (City, State, Zip Code)	
Phone	**Email**

Patient Attestation

By signing below, I understand that I am authorizing the Department of Health and Human Services, Bureau of Cannabis Regulation to share information in my confidential file pursuant to the circumstances described in Iowa Code 124E.11(1)(b)(1)(a)-(e). This will allow the Bureau of Cannabis Regulation staff to verify information with the certifying health care practitioner relating to my qualifying debilitating medical condition, and the dispensing of medical cannabis related to that condition. It will also allow the Bureau of Cannabis Regulation to complete the processing of my application and issuance of a Medical Cannabis Registration Card.

I hereby authorize the Bureau of Cannabis Regulation to exchange information about my qualifying debilitating medical condition with the certifying health care practitioner and the Iowa-licensed medical cannabis dispensaries in relation to the issuance of a Medical Cannabis Registration Card and the dispensing of any cannabis/cannabinoid product.

I certify that the information on this application is submitted for the purpose of obtaining a State of Iowa Medical Cannabis Registration Card. I acknowledge that I met with my health care practitioner and understand the possible risks, benefits and side effects of medical cannabis. If approved for the Medical Cannabis Registration Card, I agree to the terms of the Iowa Medical Cannabidiol Act chapter 124E and the associated administrative rules, Iowa Administrative Code 641—154.

I certify under penalty of perjury that all the information provided by me on this application is true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Medical Cannabis Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. I agree to notify the Bureau of Cannabis Regulation, in writing, within 10 days of any change to the information provided.

Once applications are processed, communication will be sent to your residence or email address (if provided) with further instructions.

Please provide an email address for communication and program updates.

Any Registration Card that is lost or stolen must be reported to the Bureau of Cannabis Regulation immediately. Applicant information changes that are printed on the Registration Card (such as name or address) will require a new card to be issued.

Patient Signature(required):_____ _____
Date

Legal Guardian/Power of Attorney Signature (if any):_____ _____
Date

Legal Guardian/Power of Attorney Name (if any):_____

Legal Guardian/Power of Attorney Phone (if any):_____

Adult Patient Application Checklist

1. **Patient Information and Attestation Section**
   - The form is fully filled out and the patient signed the attestation.

2. **Health Care Practitioner Certification Included**
   - Patient's health care practitioner has completed the Health Care Practitioner Certification form and certified that the patient has one or more of the qualifying debilitating medical conditions.

3. **Applicant - Patient - Documentation**
   - A clear copy of the patient's valid photo identification card must be attached.
   - This must be a valid Driver's License or a valid Nonoperator's Identification Card.

4. **Application Fee**
   - Regular application fee: $100.00
   - Reduced application fee: $25.00
     - Patient must provide ONE of the following items as proof for reduced fee. Documentation must be current within the past 12 months.
       - Social Security Disability Benefit (provide copy of current benefit notice)
       - Supplemental Security Income Payment (provide copy of current receipt)
       - Iowa Medicaid (provide copy of current member card)
       - Veteran Status (listed on your ID or provided as separate document)

To submit a paper application, mail the completed application and required materials to:

Iowa Health and Human Services
ATTN: BCR
321 E. 12th Street
Des Moines, IA 50319-0075

If the adult patient has a caregiver with responsibility for managing his or her well-being in relation to the use of medical cannabis or assists with transportation and/or handling of medical cannabis, a separate Primary Caregiver application must be completed.