



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 SECTION FOR MEDICAL MARIJUANA REGULATION  
 MEDICAL MARIJUANA REGULATORY PROGRAM  
**PATIENT REGISTRATION APPLICATION**

**Patient Registration fee: \$25.00. Cultivation fee: \$100.00. Submit application and payment with proof of Missouri residency [1]; color photo [2]; government issued identification [3]; physician certification(s) [4]; if applicable, proof of legal guardianship [5] and a completed Parental/Legal Guardian Consent Form [6]; and if applicable, a written description of the patient cultivation facility security arrangements and processes [7]. Please see instructions below for further details.**

**PERSONAL INFORMATION**

LAST NAME		FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER			STATE OF MISSOURI ID/DRIVERS LICENSE NUMBER	
DATE OF BIRTH (MM-DD-YYYY)			IS THE PATIENT 18 YEARS OR OLDER? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**CONTACT INFORMATION**

RESIDENCE ADDRESS [8]				UNIT/APT NO
CITY	STATE	COUNTY	ZIP CODE	
MAILING ADDRESS				UNIT/APT NO
CITY	STATE	COUNTY	ZIP CODE	
PHONE NUMBER		EMAIL ADDRESS		

**PATIENT CAREGIVER INFORMATION (IF APPLICABLE, INDICATE AUTHORIZED CAREGIVERS. ALL CAREGIVERS ARE REQUIRED TO SUBMIT APPLICATIONS FOR CAREGIVER REGISTRATION)**

LIST AUTHORIZED CAREGIVER NAMES

**CULTIVATION REGISTRATION**

DO YOU INTEND TO CULTIVATE MARIJUANA? [10]  
 YES  NO

**CULTIVATION SECURITY ARRANGEMENTS AND PROCESSES**

DO YOU AGREE TO IMMEDIATELY MAKE AVAILABLE ACCESS TO THE PATIENT CULTIVATION FACILITY UPON REQUEST FROM THE DEPARTMENT?  
 YES  NO

DO YOU AGREE TO MAINTAIN CULTIVATION IN AN ENCLOSED LOCKED FACILITY?  
 YES  NO

CULTIVATION STREET ADDRESS				UNIT/APT NO
CITY	STATE	COUNTY	ZIP CODE	

WILL THIS CULTIVATION FACILITY BE SHARED?  
 YES  NO

NAME OF PATIENT/CAREGIVER SHARING FACILITY [11]

LICENSE NUMBER OF PATIENT/CAREGIVER SHARING FACILITY

**REGISTRATION QUESTIONS AND AGREEMENT**

DO YOU SPEAK A LANGUAGE OTHER THAN ENGLISH?  
 YES  NO

OTHER LANGUAGE: \_\_\_\_\_

DO YOU RESIDE IN MISSOURI AND CLAIM NO RESIDENT PRIVILEGES IN ANOTHER STATE OR COUNTRY?  
 YES  NO

OPTIONAL [12]: ARE YOU CURRENTLY ELIGIBLE FOR ANY MISSOURI LOW-INCOME ASSISTANCE PROGRAMS?  
 YES  NO

IF SO, WHICH ONE(S): \_\_\_\_\_

**REGISTRATION QUESTIONS AND AGREEMENT (CONTINUED)**

DO YOU ATTEST THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT?

 YES  NO

SIGNATURE

DATE

LEGAL GUARDIAN SIGNATURE

DATE

[1] There are four ways to prove Missouri residency: 1) A copy of a valid Missouri driver's license, 2) a copy of a Missouri Identification Card, 3) a copy of a current Missouri motor vehicle registration, or 4) a copy of a recent Missouri utility bill. If none of these proofs are available, the director of the medical marijuana program may authorize other proofs. Please contact [medicalmarijuanainfo@health.mo.gov](mailto:medicalmarijuanainfo@health.mo.gov) for more information.

[2] This should be a clear, color photo of the applicant's face taken within the last three months with no sunglasses or hats.

[3] This should be a clear, readable copy of a government issued photo ID.

[4] Patients must include with this application a physician certification that is no more than thirty days old at the time the patient submits the application. If the patient requires more medical marijuana than four ounces in a thirty day period, two physician certifications are required that each specify an amount greater than four ounces. If the two physicians specify different amounts, the department will approve the lower of the two amounts. Both of these certifications must be no more than thirty days old.

[5] Acceptable proofs are: 1) A copy of a birth certificate or adoption record showing the guardian listed in this application is the applicant's parent; or 2) A copy of documentation establishing that the guardian listed in this application has legal guardianship over the applicant.

[6] This form can be found on the department website at [medicalmarijuana.mo.gov](http://medicalmarijuana.mo.gov). The form should be completed and signed by the same legal guardian who entered his or her identifying information in this application and who will also apply to serve as a primary caregiver for the applicant.

[7] This should include a description of how the patient cultivation facility complies with the definition of "enclosed, locked facility" in 19 CSR 30-95.010.

[8] This should be the address where the applicant actually resides.

[9] This person should be a person who will also apply to serve as a primary caregiver for the applicant.

[10] Details about how many plants may be grown in one facility and who may have access to it can be found in 19 CSR 30-95.030.

[11] Please include all patients and caregivers who will have access to the cultivation facility.

[12] A response to this question is optional and will only be used to flag an identification card as one that is eligible for any low-income discounts offered by dispensaries.