SB 420
Medical Marijuana Identification Card (MMIC) Program

Nevada County
Public Health Department
MMIC Program
500 Crown Point Circle
Suite 110
Grass Valley, CA 95945
Telephone: (530) 265-7264
Fax: (530) 271-0829
www.mynevadacounty.com

Sacramento
Medical Marijuana Program Unit
Office of County Health Services
California Department of Public Health
P.O. Box 997413, MS 5203
Sacramento, CA 95899-7413
Telephone: (916) 552-8600
Fax: (916) 552-8038
www.dhs.ca.gov/mmp

Applications are accepted by appointment only.

Please call (530) 265-7264 to schedule an appointment.

Fee Schedule:
Patient MMIC $100.00
Primary Caregiver MMIC $100.00
Replacement MMIC (Patient or Caregiver) $100.00
Renewal MMIC (Patient or Caregiver) $100.00

Medi-Cal participants are eligible for a 50% reduction in fees.

CMSP Participants are eligible to have the fee waived.

Application fees are non-refundable.

Dear Applicant:

Complete instructions can be found on page 4 of this application.
After completing your application, please call the MMICP Office at (530) 265-7264 to schedule your appointment.

You must bring the following items with you to your scheduled appointment:

- A completed and accurate application. Please be sure that you read it carefully and complete all the appropriate sections.
- A valid government issued photo identification.
- Proof of residency in Nevada County.
- A recommendation from your physician for medical cannabis.
- The MMIC fee (cash or money order only).
- Medi-Cal or CMSP card, if applicable.
- Attestation signed and dated by attending physician.
- Completed medical release form.
- If renewing, last year's card.

Your photo will be taken at your scheduled appointment.

Medical Marijuana Identification Card (MMIC)
Application Packet and Procedures

Before scheduling an appointment

- Obtain a written recommendation from your physician and make sure there is a copy in your medical file. *There is an optional form included in packet. If another format is used, make sure it contains the same information.*
- Give your physician a signed "Authorization for Release of Medical Records" for your medical file. The Medical Release form is in your application packet. Bring copy to appointment with application.
- Complete an application (print legibly).
- Call 530-265-1450 to schedule an appointment.

What to Bring to your scheduled appointment:

The qualified patient will need:

- The original written recommendation from your physician. (This will be returned to you at your appointment.)
- A completed application.
- Copy of Medical Release form.
- Signed and dated attending physicians Attestation form.
- A government-issued picture ID.
- Proof of residency.
- Application fee (cash or money order only).
- Medi-Cal or CMSP card, if applicable.
- Bring in old MMIC to shred.

The primary caregiver, if any, will need:

- Completed Section 4 of the application.
- A government-issued picture ID.
- Proof of residency in California.
- Attending physicians signed and dated Attestation form.
- Application fee (cash or money order only).
- Medi-Cal or CMSP card, if applicable.
- Bring in old MMIC to shred.

A digital photograph of the patient – and the primary caregiver, if any – will be taken during the appointment.

After submitting your application:

- The physician's license will be verified with the Medical Board of California or the Osteopathic Medical Board of California.
- The physician's recommendation will be verified with the physician's office.
- The Attestation will be signed again via fax to verify signature.

The Public Health Department (PHD) is required to verify the accuracy of the information in the application, and approve or deny the application within 30 days from the date we received the application. The PHD will notify the applicant if any additional information or documentation is required. The applicant will have 30 days from the date of notice to provide the missing information or documentation. If the applicant provides the missing information, the PHD has the remainder of the initial 30-day processing period *or* 14 days from receipt of the information, whichever is more, to approve or deny the application.

If approved, the following data is submitted to the state:

- Whether the card is for a patient or a primary caregiver.
- The file containing the digital photograph of the person, the cardholder.

The MMIC will be available to the applicant within 5 business days from the approval date of the application.

If denied, the applicant will be notified of the denial. The applicant will have 30 days from the date of notice to appeal the decision to the California Department of Public Health.

MEDICAL MARIJUANA PROGRAM APPLICATION/RENEWAL INSTRUCTIONS

Who may apply?

This program is voluntary. You may apply with the program if you reside in a California county and your doctor recommends the use of medical marijuana for one or more serious medical conditions you suffer from as specified in number 3 below. It is your option to designate a primary caregiver and apply for their identification card at the time you submit your application.

INSTRUCTIONS:

You must complete the *Application/Renewal* form (CDPH 9042) and provide the following information in order to receive an identification card. Submit both the CDPH 9042 and the following information to your county health department (or its designee).

1. Provide a government-issued photo identification card (such as a driver's license) issued to you.

   If you are under the age of 18 and lack photographic identification, you may substitute a certified copy of your birth certificate in place of the photo identification. If you designate a primary caregiver on your application form, your primary caregiver must present photographic identification at the same time you submit your application. A primary caregiver may use a certified birth certificate if they are under the age of 18 and lack government-issued photo identification.

2. Provide proof of your county residency with one of the following items:

   - A current rent/mortgage receipt or recent utility bill in your name bearing your current address within the county;
   - A current California motor vehicle registration in your name bearing your current address within the county; or
   - A California Driver's License or a California Identification Card issued by the California Department of Motor Vehicles (DMV) with your current address within the county listed.

   If you only possess a California Driver's License or California Identification Card with an older address listed outside the county, you may submit a DMV-issued Change of Address Certification Card (DL 43) listing your current address within the county when you present your identification. If you are less than 18 years of age, you may use any of the previously mentioned residency evidence belonging to your parent or legal guardian if they also reside in the county.

3. Written documentation from your doctor recommending that the use of medical marijuana is appropriate for one or more of the following serious medical conditions you suffer from: Acquired Immune Deficiency Syndrome (AIDS); anorexia; arthritis; cachexia; cancer; chronic pain; glaucoma; migraine; persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis; seizures, including, but not limited to, seizures associated with epilepsy; severe nausea; or any other chronic or persistent medical symptom that either substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 or, if not alleviated, such chronic or persistent medical symptoms may cause serious harm to your safety, or your physical or mental health.

4. Your doctor may use the *Written Documentation of Patient's Medical Records* form (CDPH 9044) to serve as the medical documentation. This form is in your application packet or may be obtained at the California Department of Public Health web site: http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph9044.pdf.

5. The administering agency is required to verify an applicant's medical documentation. It is the applicant's responsibility to provide the *Medical Release* form to the administering agency, included in application packet.

6. Provide the administering agency with your signed and dated attending physicians *Attestation* form, provided in application packet.

7. Medi-Cal participation at the time of application entitles the applicant to a 50 percent reduction in fees. **Application fees are nonrefundable.**

8. If you submit an incomplete application and/or fail to provide all the previously mentioned information, your application will be denied and you may be restricted from reapplying for six months.

Medical Marijuana Program
APPLICATION/RENEWAL
(Please Print)

For application instructions, view page 4.

This application is for:

☐ Patient Only (Applicant) ☐ Primary Caregiver Only ☐ Patient and Primary Caregiver

SECTION 1 TO BE COMPLETED BY ALL APPLICANTS.

Name (last, first, middle initial)

Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

Additional contact information

Is applicant under 18 years of age? ☐ Yes ☐ No

If yes, complete Section 2 for the parent, legal guardian, or person with legal authority to make medical decisions for minor applicant, unless minor applicant is *(check one)*:

☐ Lawfully emancipated; *or* ☐ Declares self-sufficient minor status or is a minor capable of medical consent

SECTION 2 TO BE COMPLETED FOR MINOR APPLICANT IDENTIFIED IN SECTION 1.

Parent/guardian/other name (last, first, middle initial)			Telephone number if different from above ( )
Mailing address if different from above (number, street)	City	State	ZIP code

Relation to applicant *(check one)*:

☐ Parent with legal authority to make medical decisions
☐ Legal Guardian
☐ Other person or entity with legal authority to make medical decisions

SECTION 3 TO BE COMPLETED IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Does the applicant have the capacity to make medical decisions? ☐ Yes ☐ No

If "No," enter the name and address of person acting on the applicant's behalf:

Name (last, first, middle initial)			Telephone number ( )
Mailing address (number, street)	City	State	ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

SECTION 4 TO BE COMPLETED BY THE PRIMARY CAREGIVER REQUESTING AN IDENTIFICATION CARD.

Name (last, first, middle initial)			Date of birth (if less than 18 years of age)
Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

Primary Caregiver Duties: *(Document how you consistently assume responsibility for the housing, health, or safety of the applicant.)*

Check your designation as a primary caregiver from the following list:

☐ I am the parent of the applicant or the person entitled to make medical decisions on behalf of the applicant.
☐ I am the designated primary caregiver for only this applicant.
☐ I am the designated primary caregiver for another applicant (qualified patient) in this county.
☐ I am the designated primary caregiver for an applicant (qualified patient) in a different county.

County name: _____

Check one of the two following choices if your status as a primary caregiver is linked to a health related entity:

☐ I am the owner/operator of a clinic pursuant to Chapter 1 (commencing with Section 1200), Division 2 of the Health and Safety (H&S) Code.
☐ I am a clinic/facility/hospice or home health agency employee* designated by the owner/operator to serve as a primary caregiver.

Check all that apply:

☐ This health care facility is licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.01 (commencing with Section 1568.01), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.2 (commencing with Section 1569), Division 2 of the H&S Code.
☐ This hospice or home health agency is licensed pursuant to Chapter 8 (commencing with Section 1725), Division 2 of the H&S Code.

* Health and Safety Code, Section 11362.7(d)(1), limits a maximum of three employees that may serve as primary caregivers. **Note:** Include a copy of this page for each caregiver.

Primary Caregiver Declaration: I understand and acknowledge my assigned duties as the designated primary caregiver for

_____. I understand that if the applicant's identification card expires, then my primary caregiver
Applicant's name

identification card shall also expire. I agree to return my primary caregiver identification card to this county health department or its designee if this applicant changes primary caregivers. I agree that if I am the owner or operator of a health care facility designated as the primary caregiver of this applicant, that I shall notify this county health department or its designee if a change of primary caregivers is made. I declare under penalty of perjury that the information I provided on this form is true and correct.

_____
Printed name of primary caregiver

_____ _____
Signature of primary caregiver Date

SECTION 5 **ALL APPLICANTS MUST IDENTIFY THEIR ATTENDING PHYSICIAN.**

Attending physician name			California medical license number
Service mailing address (number, street)			Licensed by *(check one)*
			☐ Medical Board of California ☐ Osteopathic Medical Board of California
City	State	ZIP code	
Office telephone number ( )	Office fax number ( )		

Notice Required by Civil Code, Section 1798.17

The Civil Code, Section 1798.17, requires that this notice be provided when collecting personal or confidential information from individuals. Providing the individual information and identifying information requested on this form is mandatory. Failure to furnish this information to the administering agency, in order to process your application for a medical marijuana identification card, will result in denial of your application. The information collected will be verified for accuracy to determine eligibility for a medical marijuana identification card. Sections 11362.71 and 11362.715 of the Health and Safety Code authorize the collection and maintenance of the information.

The Compassionate Use Act of 1996 (Act) (Health & Safety Code, Section 11362.5) ensures that patients and their primary caregivers who possess or cultivate marijuana for the personal medical purposes of the patient upon the recommendation of a physician are not subject to California criminal prosecution or sanction. However, the Act does not protect marijuana plants from seizure nor individuals from federal prosecution under the federal Controlled Substances Act. The information that you provide in this application may be released as required by law, judicial order, or subpoena, and could be used in a federal criminal prosecution.

You have the right to access records containing your personal information which are maintained by the county health department, or the county's designee, and the California Department of Public Health.

Responsibilities

It is my responsibility:

- To notify, within seven days, the county health department or the county’s designee of any changes in my attending physician or designated primary caregiver.
- To use my identification card only for the purposes intended by the law.
- To ensure that an authorized medical release of information is on file with my medical provider in order to complete my application.

Declaration

I have read the notice required by Civil Code, Section 1798.17 and understand my responsibilities as stated above concerning my participation in the Medical Marijuana Program. I confirm to the best of my knowledge the listed duties and information provided by my primary caregiver. I declare under penalty of perjury that the information I provided on and with this application is true and correct.

Print name of applicant or legal representative

Signature of applicant or legal representative

Date

Medical Marijuana Program
WRITTEN DOCUMENTATION OF PATIENT'S MEDICAL RECORDS
(Please Print)

Note to Attending Physician: This is not a mandatory form. If used, this form will serve as written documentation from the attending physician, stating that the patient has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate. A copy of this form must be filed in the attending physician's medical records for the patient. If the patient chooses to apply for a Medical Marijuana Identification card through the county health department or its designee, the agency will call the attending physician to verify the information contained on this form, in accordance with Health & Safety Code, Section11362.72 (a)(3).

Attending physician name			California medical license number
Service mailing address (number, street)			Office telephone number ( )
City	State	ZIP code	Office fax number ( )

Licensed by *(check one)*:

☐ Medical Board of California ☐ Osteopathic Medical Board of California

_____ is a patient under the medical care and supervision of the above
Patient's name

named physician who has diagnosed the patient with one or more of the following medical conditions:

1. Acquired Immune Deficiency Syndrome (AIDS)
2. Anorexia
3. Arthritis
4. Cachexia
5. Cancer
6. Chronic pain
7. Glaucoma
8. Migraine
9. Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis
10. Seizures, including, but not limited to, seizures associated with epilepsy
11. Severe nausea
12. Any other chronic or persistent medical symptom that either:
    a. Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990.
    b. If not alleviated, may cause serious harm to the patient's safety or physical or mental health

ATTENDING PHYSICIAN STATEMENT:

This patient has been diagnosed with one or more of the foregoing medical conditions and the use of medical marijuana is appropriate.

Attending physician's signature	Telephone number	Date

Original—Patient Copy—Patient's File

AUTHORIZATION FOR RELEASE OF INFORMATION

Please **PRINT**

1. I, _____ (Date of Birth): _____ authorize:

   Name: _____

   Address: _____

   City/State/Zip _____

   To release copies of my medical record to:

   NEVADA COUNTY PUBLIC HEALTH DEPARTMENT
   500 CROWN POINT CIRCLE SUITE 110
   GRASS VALLEY, CA 95945

   Phone Number: (530) 265-7264
   Fax Number: (530) 271-0829

2. Specific information I am authorizing to be released is as follows:

   ❑ All records authorizing the use of Medical Marijuana.

   _____

   _____

   _____

   Dates covered: _____ (month/year) to _____ (month/year)

3. Purpose(s) or need for which information is to be used:

   ❑ For the issuance of a Medical Marijuana Identification Card (MMIC)

4. I understand that:
   - √ This authorization is valid for 90 days after the date of my signature subject to legal counsel and State law.
   - √ This authorization can be revoked, except to the extent that action has already been taken to comply with it.
   - √ Information documented in my record after the date of my signature will not be released.
   - √ The information released cannot be re-disclosed by Nevada County Public Health Department unless I specifically authorize such a release in writing.

_____ _____
(Date) (Signature of Client or Legal Representative)

_____
(Legal Representative's Relationship to Client)

Medical Marijuana Program
DENIAL APPEALS APPLICATION
(Please Print)

Instructions: Use this form to appeal your county's denial of your application for a Medical Marijuana Program Identification Card. This form must be completed by you (the applicant) or by the legal representative specified below in Section 3. Within 30 calendar days from the date you were notified of your application denial, mail this completed form and a copy of your denied application to:

California Department of Public Health
Office of County Health Services
Appeals Desk, Medical Marijuana Program
MS 5203
P.O. Box 997377
Sacramento, CA 95899-7377

For further information, please contact the Medical Marijuana Program at (916) 552-8600.

Note: In order to process this appeal, the California Department of Public Health (CDPH) requires all applicable sections on this form be complete, including the signed declaration. Failure to furnish the authorization in Section 5 and all information required on this form will result in a denial of the appeal.

SECTION 1: INDICATE BY CHECKMARK BELOW IF THIS APPEAL IS FOR YOURSELF (APPLICANT), YOUR PRIMARY CAREGIVER, OR BOTH

☐ Patient (applicant) card ☐ Primary caregiver card

SECTION 2 COMPLETE THE APPLICANT INFORMATION BELOW.

Name (last, first, middle initial)

Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

SECTION 3 COMPLETE THIS SECTION IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Name (last, first, middle initial)		Telephone number ( )	
Mailing address (number, street)	City	State	ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:
☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

SECTION 4 COMPLETE THIS SECTION IF THE APPEAL IS FOR YOUR PRIMARY CAREGIVER.

Name (last, first, middle initial)

SECTION 5 EXPLAIN IN THIS SECTION WHY YOU DISAGREE WITH YOUR COUNTY'S DENIAL.

Note: You may attach additional pages or type your statement on separate sheets and attach them to this form. Sign and date any additional pages.

Declaration *(Required)*

By submitting this appeal to the California Department of Public Health, I hereby authorize my county to release to the California Department of Public Health all information relating to my application for a Medical Marijuana Program Identification Card. I authorize this release for the sole purpose of reviewing and evaluating my appeal. This authorization is effective for the duration of the appeals process. I declare under penalty of perjury that the information on this form and any additional information submitted with this form are true and correct.

Print name of applicant or legal representative as identified in Section 3

Signature of applicant or legal representative as identified in Section 3

Date

NEVADA COUNTY
Public Health

MEDICAL MARIJUANA IDENTIFICATION CARD PROGRAM – PHYSICIAN ATTESTATION

This form must be completed by a Medical Marijuana Identification Card Program (MMICP) applicant's physician recommending the use of medical cannabis as appropriate for one or more serious medical conditions. Physicians or surgeons recommending medical cannabis for their patients who knowingly provide inaccurate or false information are in violation of the Business and Professions Code and the Health and Safety Code.

Certification

Attending Physician Name			Office Telephone Number
Mailing Address			Office Fax Number
City	State	Zip Code	Cell Number or Email Address
California Medical License Number			
Licensed By (check one): ☐ Medical Board of California ☐ Osteopathic Medical Board of California ☐ The California Board of Podiatric Medicine			
Patient Name			Patient Date of Birth

I hereby certify that in recommending medicinal cannabis to the patient named above, I have complied with all provisions of the Business and Professions Code Division 2. Chapter 5. Article 25. Recommending Medical Cannabis as outlined below.

Physician or Surgeon Signature: _____

Date (MM/DD/YYYY) _____

Business and Professions Code Division 2. Chapter 5. Article 25. Recommending Medical Cannabis:

2525. (a) It is unlawful for a physician and surgeon who recommends cannabis to a patient for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility issued a state license pursuant to Chapter 3.5 (commencing with Section 19300) of Division 8, if the physician and surgeon or his or her immediate family have a financial interest in that facility.
(b) For the purposes of this section, "financial interest" shall have the same meaning as in Section 650.01.
(c) A violation of this section shall be a misdemeanor punishable by up to one year in county jail and a fine of up to five thousand dollars ($5,000) or by civil penalties of up to five thousand dollars ($5,000) and shall constitute unprofessional conduct.

2525.2. An individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California shall not recommend medical cannabis to a patient, unless that person is the patient's attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code.

2525.3. Recommending medical cannabis to a patient for a medical purpose without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

2525.4. It is unprofessional conduct for any attending physician recommending medical cannabis to be employed by, or enter into any other agreement with, any person or entity dispensing medical cannabis.

2525.5. (a) A person shall not distribute any form of advertising for physician recommendations for medical cannabis in California unless the advertisement bears the following notice to consumers:

NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use cannabis for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of medical cannabis. Recommendations must come from an attending physician as defined in Section 11362.7 of the Health and Safety Code. Cannabis is a Schedule I drug according to the federal Controlled Substances Act. Activity related to cannabis use is subject to federal prosecution, regardless of the protections provided by state law.

(b) Advertising for attending physician recommendations for medical cannabis shall meet all of the requirements in Section 651. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discounts, premiums, gifts, or statements of a similar nature.