Instructions: Please complete all required fields (*), sign and date, and submit **with a copy of your patient certification** using the instructions below. Type or print clearly in all fields to avoid unnecessary delay in processing your registration.

Patient Information

*Patient Certification Number: PC _____

*First Name: _____ *Last Name: _____

*Date of Birth: _____

*Street Address _____ * State: ____ *Zip Code:_____

*Mailing Address (if different from your street address): _____

*Phone Number : _____

E-mail Address (Optional): _____

NYS DMV ID #: _____

Patient my.ny.gov User ID: _____

Patients who do NOT have a NYS DMV ID # are required to submit a photo.

Please submit a headshot photo (selfie) of yourself against a plain background and submit the registration back to us via email, fax or US Postal Service for review. We do not accept a photo of a photo, or a photo with filters. Photos should be in.jpg or .jpeg formats; min size: 18KB, max size: 4GB, portrait orientation.

****If the applicant for a registry identification card is under the age of eighteen (18) or a person who is otherwise incapable of consenting to medical treatment, the application must be submitted by an appropriate person over twenty-one (21) years of age. The applicant must designate at least one, caregiver below.**

Patient Attestation

I attest and affirm the truth of the information I have provided in this application and acknowledge that making a false statement in the application is punishable as a Class A misdemeanor under section 210.45 of the New York State Penal Law. I understand that the Office of Cannabis Management may request additional information from me, or my certifying practitioner, to verify information in my application. I authorize the New York State Department of Motor Vehicles to release to the Office of Cannabis Management personal identity information, including: my name, client identification number, date of birth, address and digital image, for verification and use on my Medical Cannabis Registry Identification Card.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Submit this form along with a **COPY** of the patient certification, and a photo if necessary, via one of the following methods, please do not do both:

- E-mail the completed form to medical@ocm.ny.gov
- Fax a copy to 518-474-6355
- Mail a copy to:

  NYS Office of Cannabis Management
  PO Box 2071
  Albany, NY 12220

Designated Caregiver Information

Instructions: Complete this section to add a Designated Caregiver to your registration to assist you with the purchase, and/or administration of your medical cannabis. Complete all required fields (*), sign and date, and submit using the instructions below. Type or print clearly in all fields to avoid unnecessary delay in processing your registration.

When adding a caregiver, pages 1-4 must be completed, signed and submitted as directed below or caregiver can not be added to your registration.

*Designated Caregiver First Name: _____

*Last Name: _____ Date of Birth: _____

*Street Address: _____ *City:_____ *State: _____

*Zip Code: _____ * Phone Number: _____

E-mail Address (Optional): _____

*DMV ID#: _____ *DMV ID State: _____

Caregiver my.ny.gov User ID: _____

Designated Caregiver Attestation

I attest and affirm the truth of the information I have provided in this application and acknowledge that making a false statement in the application is punishable as a Class A misdemeanor under section 210.45 of the New York State Penal Law. I attest that I am not the certified patient's practitioner. I agree to secure and ensure proper handling of all approved medical marijuana products for the certified patient for whom I am the designated caregiver. I attest that I am not currently a designated caregiver for five current certified patients, and I have not submitted an application which is pending, and if approved would cause me to be a designated caregiver for more than five current certified patients. I acknowledge that the Office of Cannabis Management may request additional information from me to verify information in my application. I authorize the New York State Department of Motor Vehicles to release to the Office of Cannabis Management personal identity information, including: my name, client identification number, date of birth, address and digital image, for verification and use on my Medical Cannabis Registry Identification Card.

Caregiver Name (Print): _____

Caregiver Signature: _____ Date:_____

Submit this form along with a **COPY** of the patient certification, and a photo if necessary, via one of the following methods, please do not do both:

- E-mail the completed form to medical@ocm.ny.gov
- Fax a copy to 518-474-6355
- Mail a copy to:

  NYS Office of Cannabis Management
  PO Box 2071
  Albany, NY 12220