STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGAL AND REGULATORY SERVICES

BUREAU OF GENERAL COUNSEL – ADMINISTRATIVE RULES UNIT

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May 14, 2021

David J. Alukonis, Director
Office of Legislative Services – Administrative Rules
25 Capitol Street
State House Annex, Room 219
Concord, NH 03301

RE: Notice Number: 2020-106

Dear Mr. Alukonis:

Enclosed is a "Conditional Approval Request" for proposed rule He-C 401 entitled "Therapeutic Cannabis Program-Registry Rules".

The conditional approval request makes changes in response to comments from the office of legislative services (OLS) staff attorney along with a few programmatic changes.

The NH Department of Health and Human Services submits this rule for review and approval by the Joint Legislative Committee on Administrative Rules at its next regular meeting on **May 21, 2021.**

Thank you for your cooperation and assistance with this process.

Sincerely,

Allyson E. Zinno
Administrator-Administrative Rules Unit

Enclosure

Substantive comments pages 13, 26, 28, 30, 31, 32, and 35.

CHAPTER He-C 400 THERAPEUTIC CANNABIS PROGRAM

PART He-C 401 THERAPEUTIC CANNABIS PROGRAM – REGISTRY RULES

Statutory Authority: RSA 126-X:6, I

Readopt with amendment He-C 401.01, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.01 Purpose and Scope.

(a) The purpose of these rules is to establish the requirements for issuing registry identification cards to qualifying patients and their designated caregivers for the therapeutic use of cannabis.

(b) Individuals who are not legal residents of the state of New Hampshire shall not be eligible to receive registry identification cards as qualifying patients.

Readopt with amendment He-C 401.02, effective 11-2-15 (Document #10646), as amended effective 11-2-15 (Document #10964), to read as follows:

He-C 401.02 Definitions.

(a) "Alternative treatment center (ATC)" means "alternative treatment center" as defined in RSA 126-X:1, I, namely, "a not-for-profit entity registered under RSA 126-X:7 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies, and dispenses cannabis, and related supplies and educational materials, to qualifying patients and alternative treatment centers."

(b) "Cannabis" means "cannabis" as defined in RSA 126-X:1, III, namely, "all parts of any plant of the Cannabis genus of plants, whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. Such term shall not include the mature stalks of such plants, fiber produced from such stalks, oil, or cake made from the seeds of such plants, any other compound, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil or cake, or the sterilized seeds of such plants which are incapable of germination. In this chapter, cannabis shall not include hemp grown, processed, marketed, or sold under RSA 439-A."

(c) "Cannabis concentrate" means any form of cannabinoid extracted from usable cannabis plant material using an extraction method, such as water, food, carbon dioxide, alcohol, or other solvent as allowed by He-C 402.16(j)(1)c.

(d) "Commissioner" means the commissioner of the New Hampshire department of health and human services, or ~~their~~ designee.

(e) "Department" means the New Hampshire department of health and human services.

(f) "Diversion" means the obtaining or transferring of cannabis from a legal possession or use to an illegal use or to a person not authorized to use or obtain cannabis under RSA 126-X or He-C 401.

(g) "Designated caregiver" means "designated caregiver" as defined in RSA 126-X:1, VI, namely, "an individual who:

(a) Is at least 21 years of age;

(b) Has agreed to assist with one or more (not to exceed 5) qualifying patient's therapeutic use of cannabis, except if the qualifying patient and designated caregiver each live greater than 50 miles from the nearest alternative treatment center, in which case the designated caregiver may assist with the therapeutic use of cannabis for up to 9 qualifying patients;

(c) Has never been convicted of a felony or any felony drug-related offense; and

(d) Possesses a valid registry identification card issued pursuant to RSA 126-X:4."

This term includes "caregiver."

(h) "Minor" means an individual who is under 18 years of age.

(i) "Provider" means "provider" as defined in RSA 126-X:1, VII(a), namely:

"(1) A physician licensed to prescribe drugs to humans under RSA 329 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances;

(2) An advanced practice registered nurse licensed pursuant to RSA 326-B:18 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances;

(3) A physician or advanced practice registered nurse licensed to prescribe drugs to humans under the relevant state licensing laws in Maine, Massachusetts, or Vermont and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances and who is primarily responsible for the patient's care related to his or her qualifying medical condition; or

(4) A physician assistant licensed pursuant to RSA 328-D and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances, with the express consent of the supervising physician."

(j) "Provider-patient relationship" means "provider-patient relationship" as defined in RSA 126-X:1, VIII, namely, "a medical relationship between a licensed provider and a patient that includes an in-person exam, a history, a diagnosis, and a treatment plan appropriate for the licensee's medical specialty."

(k) "Qualifying medical condition" means:

(1) "Qualifying medical condition" as defined in RSA 126-X:1, IX(a), namely, "the presence of:

(1) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, ulcerative colitis, Ehlers-Danlos syndrome, or one or more injuries or conditions that has resulted in one or more qualifying symptoms under subparagraph (2); and

(2) A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced

anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms;" or

(2) "Qualifying medical condition" as defined in RSA 126-X:1, IX(b), namely:

"(1) Moderate to severe chronic pain.

(2) Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects.

(3) Moderate or severe post-traumatic stress disorder."

(l) "Qualifying patient" means "qualifying patient" as defined in RSA 126-X:1, X, namely "a resident of New Hampshire who has been diagnosed by a provider as having a qualifying medical condition and who possesses a valid registry identification card issued pursuant to RSA 126-X:4." This term includes "patient."

(m) "Registry identification card" means "registry identification card" as defined in RSA 126-X:1, XI, namely, "a document indicating the date issued and expiration date by the department pursuant to RSA 126-X:4 that identifies an individual as a qualifying patient or a designated caregiver." This term includes "registry ID card~~.~~" used on department forms.

(n) "Therapeutic use" means "therapeutic use" as defined in RSA 126-X:1, XIII, namely, "the acquisition, possession, cultivation, preparation, use, delivery, transfer, or transportation of cannabis or paraphernalia relating to the administration of cannabis to treat or alleviate a qualifying patient's qualifying medical condition or symptoms or results of treatment associated with the qualifying patient's qualifying medical condition. It shall not include:

(a) The use of cannabis by a designated caregiver who is not a qualifying patient; or

(b) Cultivation or purchase by a visiting qualifying patient; or

(c) Cultivation by a designated caregiver or qualifying patient."

(o) "Visiting qualifying patient" means "visiting qualifying patient" as defined in RSA 126-X:1, XVI, namely, "a patient with a qualifying medical condition who is not a resident of New Hampshire or who has been a resident of New Hampshire for fewer than 30 days and is not eligible to purchase therapeutic cannabis in New Hampshire or receive cannabis from a qualifying New Hampshire patient."

(p) "Written certification" means "written certification" as defined in RSA 126-X:1, XVII, namely, "documentation of a qualifying medical condition by a provider pursuant to rules adopted by the department pursuant to RSA 541-A for the purpose of issuing registry identification cards, after having completed a full assessment of the patient's medical history and current medical condition made in the course of a provider-patient relationship. The date of issuance and the patient's qualifying medical condition, symptoms or side effects, the certifying provider's name, medical specialty, and signature shall be specified on the written certification.

Readopt with amendment He-C 401.03, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.03 Registry Identification Card Required.

(a) In order to receive legal protection for the therapeutic use of cannabis as authorized by RSA 126-X, an individual shall apply for and receive a registry identification card for the therapeutic use of cannabis.

(b) A qQualifying patients andor designated caregivers shall possessbe in possession of their registry identification card at all times their registry identification cards while in possession of cannabis outside their home(s).

(c) Pursuant to RSA 126-X:3, V, a qualifying patients andor designated caregivers who areis found to be in possession of cannabis outside of their home(s) and are is not in possession of their registry identification cards shall be subject to a fine of up to $100.

Readopt with amendment He-C 401.04 through He-C 401.08, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.04 Initial Application Requirements for Qualifying Patients.

(a) Applicants for a qualifying patient registry identification card shall submit a completed "Patient Application" form to the department, which includes the following:

(1) Indication whether it is an initial or renewal application;

(2) The following applicant information:

a. Full name;

b. Date of birth;

c. Gender;

d. Telephone number;

e. Optional e-mail address;

f. Mailing address; and

g. Physical address, if different than mailing address, except that if the applicant is experiencing homelessness this shall not be required;

(3) The following information about the applicant's certifying provider:

a. First and last name;

b. Business address; and

c. Telephone number;

(4) A signed and dated release authorizing the release of relevant medical information by the certifying provider to the department if further information about the applicant's qualifying medical condition or written certification is required by the department;

(5) The name and city or town of the applicant's designated ATC;

(6) The following information about the applicant's designated caregiver, if the applicant has designated a caregiver:

a. Full name;

b. Mailing address; and

c. Date of birth;

(7) A signed and dated attestation of the following acknowledgements:

a. "I understand that my Registry ID Card is valid for one year, unless a shorter time period is indicated by my provider. I must renew my card every year by submitting another application, certification, and fee.";

b. "I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.";

c. "I understand that I may not possess, between myself and my Designated Caregiver, more than two ounces of usable cannabis.";

d. "I understand that I may only use therapeutic cannabis for the purpose of treating or alleviating my qualifying medical condition.";

e. "I understand that I may not be under the influence of therapeutic cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in my place of employment, without the written permission of my employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.";

f. "I understand that I may not smoke or vaporize therapeutic cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field.";

g. "I understand that I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.";

h. "I understand that I may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property.";

i. "I have instructed a family member, caretaker, executor, and my Designated Caregiver that, in the event of my death, the Department shall be notified within 5 days that I have died, and that within 5 days of learning of my death, the family member, caretaker, executor,

or my Designated Caregiver shall either request that the local law enforcement agency remove any remaining cannabis or dispose of the cannabis in a manner that is specified in RSA 126-X:2, XIV.";

j. "I understand that if I am found to be in possession of therapeutic cannabis outside of my home and I am not in possession of my Registry ID Card, I may be subject to a fine of up to $100.";

k. "I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to RSA 126-X.";

l. "I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within New Hampshire.";

m. "I understand that I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke my Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder."; and

n. "I understand that by using therapeutic cannabis I may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.";

(8) A signed and dated certification that:

a. The applicant is a resident of New Hampshire;

b. The facts as stated in the application are accurate to the best of the applicant's knowledge and belief; and

c. The applicant understands that any false statements made on the application are punishable as unsworn falsification under RSA 641:3;

(9) A signed and dated pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, ~~and~~ acknowledgement that diversion of cannabis ~~is punishable as a class B felony and~~ shall result in revocation of their registry identification card, and acknowledgement that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis; and

(10) Voluntary demographic information, as follows:

a. Race and ethnicity;

b. Veteran status;

c. Employment and income;

d. Public assistance;

e. Education;

f. Health insurance;

g. Marital status; and

h. Language proficiency.

(b) In addition to (a) above, applicants shall provide to the department the following supporting documentation:

(1) A "Written Certification for the Therapeutic Use of Cannabis" form completed by the applicant's provider in accordance with He-C 401.07, except that a written certification completed more than 6 months prior to the date of the applicant's application submission shall not be accepted;

(2) A fee in accordance with He-C 401.14(b)(1); and

(3) Proof of New Hampshire residency, as follows:

a. A copy of the applicant's valid, non-expired New Hampshire driver's license or New Hampshire state identification;

b. A copy of the applicant's valid, non-expired state or federal government-issued identification that shows the applicant's name and New Hampshire address; or

c. If documentation in a. and b. above is unavailable, other documentation that contains the applicant's name and current address and which indicates New Hampshire residency, such as:

1. A current lease agreement or vehicle registration; or

2. A utility bill, medical bill, property tax bill, mortgage statement, bank statement, government check, or payroll check with a date showing that it was issued within 6 months of the date the application was received by the department.

(c) The applicant shall submit the documents in (a) and (b) above to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301

He-C 401.05 Initial Application Requirements for Designated Caregivers.

(a) Applicants for a designated caregiver registry identification card shall submit a completed "Caregiver Application" form to the department, which includes the following:

(1) Indication whether it is an initial or renewal application, and if an initial application, whether the applicant submitted the criminal record authorization form and fee to the NH department of safety;

(2) The following applicant information:

a. Full name;

b. Date of birth;

c. Gender;

d. Telephone number;

e. Optional e-mail address;

f. Mailing address; and

g. Physical address, if different than mailing address;

(3) The following information for each qualifying patient the applicant will be assisting with the therapeutic use of cannabis, which shall not exceed 5 qualifying patients, except that additional qualifying patients shall be allowed, up to a maximum of 9, if both the designated caregiver and the additional qualifying patients each live greater than 50 miles from the nearest ATC:

a. Full name;

b. Mailing address;

c. Physical address, if different than mailing address, except that if the qualifying patient is experiencing homelessness this shall not be required; and

d. Date of birth;

(4) A signed and dated attestation of the following acknowledgements:

a. "I understand that my Registry ID Card is valid for one year, unless a shorter duration is indicated. I must renew my card every year by submitting another application.";

b. "I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.";

c. "I understand that I may not possess, between myself and my Qualifying Patient(s), more than two ounces of usable cannabis per Qualifying Patient.";

d. "I understand that as a Designated Caregiver I am not permitted to use therapeutic cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so.";

e. "I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X.";

f. "I understand that I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.";

g. "I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Department of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV.";

h. "I understand that if I am found to be in possession of therapeutic cannabis outside of my home and I am not in possession of my Registry ID Card, I may be subject to a fine of up to $100.";

i. "I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.";

j "I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within New Hampshire.";

k. "I understand that I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke my Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder."; and

l. "I understand that I, by possessing therapeutic cannabis, and my Qualifying Patient, by using therapeutic cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.";

(5) A signed and dated certification that:

a. The applicant agrees to act as the designated caregiver for the qualifying patient named in the application;

b. The facts as stated in the application are accurate to the best of the applicant's knowledge and belief; and

c. The applicant understands that any false statements made on the application are punishable as unsworn falsification under RSA 641:3;

(6) A signed and dated pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, ~~and~~ acknowledgement that diversion of cannabis ~~is punishable as a class B felony and~~ shall result in revocation of their registry identification card, and acknowledgement that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis; and

(7) Voluntary demographic information, as follows:

a. Race and ethnicity;

b. Veteran status;

c. Employment and income;

d. Public assistance;

e. Education;

f. Health insurance;

g. Marital status; and

h. Language proficiency.

(b) In addition to the materials in (a) above, for each applicant the department shall also receive the results of a state and federal criminal history records check from the division of state police, department of safety. An application shall not be considered complete without the results of a state and federal criminal history records check.

(c) In order for the department to receive the results of a state and federal criminal history records check, an applicant shall submit to the division of state police the following:

(1) A criminal history record information authorization form, as provided by the division of state police, which authorizes the release of any felony convictions to the department;

(2) A complete set of electronic fingerprints taken by a qualified law enforcement agency or an authorized employee of the department of safety; and

(3) The required fee.

(d) In the event that, after 2 attempts, the applicant's electronic fingerprints are invalid due to insufficient pattern, the department shall, in lieu of the criminal history records check, accept the results of police clearances showing no felony convictions from every city, town, or county where the person has lived during the past 5 years, including any out-of-state residency, received from the division of state police.

(e) The applicant shall submit the documents in (a) above to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301

He-C 401.06 Provider Requirements.

(a) The department shall accept written certifications for the therapeutic use of cannabis only from providers who possess, at the time of signing the certification, the following:

(1) For providers in New Hampshire, an active license, in good standing, pursuant to RSA 329 for physicians, pursuant to RSA 326-B:18 for advanced practice registered nurses, or pursuant to RSA 328-D for physician assistants;

(2) For providers in Maine, Massachusetts, and Vermont, an active license, in good standing, pursuant to the relevant state licensing laws in Maine, Massachusetts, or Vermont, except that a license for a naturopathic doctor shall not be acceptable; and

(3) For all providers in (1) and (2) above, an active registration from the United States Drug Enforcement Administration to prescribe controlled substances.

(b) A provider issuing a written certification shall:

(1) Have a provider-patient relationship with the patient, as defined in He-C 401.02(j);

(2) If a provider licensed in Maine, Massachusetts, or Vermont, be primarily responsible for the patient's care related to the patient's qualifying medical condition, pursuant to RSA 126-X:1, VII(a)(3);

(3) If a physician assistant, have the express consent of the supervising physician, pursuant to RSA 126-X:1, VII(a)(4);

(4) Conduct a full assessment of the patient's medical history and current medical condition which includes:

a. An in-person physical examination of the patient, which shall not be via telemedicine, except that telemedicine shall be allowed for New Hampshire providers for follow-up visits related to cannabis certification and treatment and for recertifications completed by the same certifying provider;

b. A medical history of the patient, including a prescription history;

c. A review of laboratory testing, imaging, and other relevant tests;

d. Appropriate consultations;

e. A documented diagnosis of the patient's current medical condition; and

f. The development or documentation of a treatment plan for the patient appropriate for the provider's specialty;

(5) Explain the potential health effects of the therapeutic use of cannabis:

a. To the patient; or

b. In the case of a patient who is a minor, to the minor's custodial parent or legal guardian with responsibility for health care decisions for the patient, which shall be inclusive of potential risks and benefits of the therapeutic use of cannabis;

(6) Follow the patient clinically at appropriate intervals at the discretion of the provider to provide follow-up care and treatment to the patient for the patient's qualifying medical condition including, but not limited to, physical examinations, to determine the health effects of cannabis for treating the patient's qualifying medical condition or associated symptom for which the written certification was issued;

(7) Maintain medical records for all patients for whom the provider has issued a written certification which support the written certification;

(8) Make a copy of such records which support the written certification available to the department, and otherwise provide information to the department upon request about the patient's qualifying medical condition, to ensure compliance with RSA 126-X and He-C 401; and

(9) If the provider has recommendations or instructions for the therapeutic use of cannabis for the patient, be permitted to send such recommendations or instructions to the patient's designated ATC. Such recommendations shall be securely transmitted.

(c) A provider shall not consider a patient to have a qualifying medical condition if a patient who has had a diagnosis of a qualifying medical condition in the past no longer actively has a qualifying medical condition, unless the symptoms related to such qualifying medical condition are mitigated by the therapeutic use of cannabis.

(d) Providers shall not issue a written certification for themselves or for the provider's immediate family members.

(e) A provider shall not:

(1) Offer a discount or other thing of value to a patient who uses or agrees to use a particular ATC;

(2) Examine a patient in relation to issuing a written certification at a location where cannabis is sold or distributed; or

(3) Hold any economic interest in an ATC, including but not limited to employment at an ATC, if the provider issues written certifications to patients.

(f) Providers may rescind or otherwise withdraw a written certification which they have previously issued, for cause, including, but not limited to, the provider making a determination that the patient:

(1) No longer has a qualifying medical condition;

(2) Should discontinue using cannabis;

(3) Falsified information that was the basis of the provider's written certification;

(4) Did not adhere to the provider's treatment plan for the patient; or

(5) Should no longer be certified for the therapeutic use of cannabis for another compelling reason.

(g) To rescind or otherwise withdraw a previously issued written certification, the certifying provider shall submit the following information on the "Written Certification Withdrawal" form:

(1) Qualifying patient name;

(2) Qualifying patient date of birth;

(3) Certifying provider name;

(4) Medical practice phone number;

(5) Reason for withdrawal of the written certification; and

(6) Certifying provider's dated signature of a statement of withdrawal for the reason in (5) above.

(h) Providers may extend the duration of a written certification, as follows:

(1) Providers may extend the duration of a written certification that they previously issued which has a duration of less than one year, per He-C 401.07(b)(7);

(2) The extension period shall not be for a duration longer than the maximum duration of a registry identification card established in RSA 126-X:4, IV;

(3) An extension request shall be submitted prior to the expiration of the qualifying patient's registry identification card; and

(4) An extension request shall not require the submission of a new written certification, a new patient application, or a new fee.

(i) To extend the duration of a written certification, the certifying provider shall submit written notice to the department by submitting the following information on the "Written Certification Extension" form:

Legis. Intent. The rule now proposes to adopt the elements of a new form "Written Certification Extension" and the form submitted with the initial proposal indicated an edition date of May 2020. See attachment. The JLCAR may have questions about whether the Department has been requiring the use of the form (which is a rule) prior to approval, contrary to RSA 541-A:22, I..

(1) Qualifying patient name;

(2) Qualifying patient date of birth;

(3) Certifying provider name;

(4) Medical practice phone number;

(5) Length of extension; and

(6) Certifying provider's dated signature.

(j) Upon receipt of the completed written notice in (i) above, the department shall issue a new registry identification card with a new expiration date.

He-C 401.07 <u>Written Certification Requirements</u>.

(a) The certifying provider shall complete a "Written Certification for the Therapeutic Use of Cannabis~~,~~" form, which includes the following:

(1) Indication whether it is an initial or renewal certification;

(2) The following patient information:

a. Full name;

b. Mailing address;

c. Telephone number; and

d. Date of birth; and

(3) The following provider information:

a. Full name;

b. Name of medical practice;

c. Office mailing address;

d. Office telephone and fax numbers;

e. Optional email address;

f. State license number;

g. Indication that the provider is a physician, an advanced practice registered nurse, or a physician assistant;

h. Active US Drug Enforcement Administration registration number; and

i. Medical specialty, as appropriate for the provider type.

(b) On the "Written Certification for the Therapeutic Use of Cannabis~~,~~" form, the provider shall:

(1) Certify that the patient has a qualifying medical condition, as defined in He-C 401.02(j) and RSA 126-X:1, IX(a) or (b), by:

a. Providing the patient's name;

b. Indicating which condition(s) the patient has; and

c. Signing and dating the certification;

(2) Indicate whether the written certification is based on an in-person physical examination that was conducted via telemedicine;

(3) Certify that the provider has a provider-patient relationship with the patient, as follows:

"I have completed a full assessment of my patient's medical history and current medical condition in accordance with He-C 401.06(b)(4) made in the course of a provider-patient relationship";

(4) Certify that the provider explained the potential health effects of the therapeutic use of cannabis:

a. To the patient; or

b. In the case of a patient who is a minor, to the patient's custodial parent or legal guardian with responsibility for health care decisions for the patient, which shall be inclusive of the potential risks and benefits of the therapeutic use of cannabis;

(5) Certify that the provider possesses an active license in good standing with the state of New Hampshire or the state of Maine, Massachusetts, or Vermont and is either:

a. A physician, an advanced practice registered nurse, or a physician assistant licensed in New Hampshire to prescribe drugs to humans under RSA 329, RSA 326-B:18, or RSA 328-D, respectively, and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances; or

b. A physician or an advanced practice registered nurse licensed in Maine, Massachusetts, or Vermont to prescribe drugs to humans under the relevant state licensing laws, who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances, and who is primarily responsible for the patient's care related to the patient's qualifying medical condition;

(6) Certify that the facts as stated in the written certification are accurate to the best of the provider's knowledge and belief and that the provider understands that any false statements made on the written certification are punishable as unsworn falsification under RSA 641:3; and

(7) Indicate the duration for which the registry identification card shall be valid, if for a shorter duration than one year from the effective date of the card, except that if this is not indicated, the card shall default to a duration of one year.

He-C 401.08 Initial Application Requirements for Minor Patients.

(a) The minor applicant's custodial parent(s) or legal guardian who is responsible for the health care decisions of the minor applicant shall complete and submit the "Minor Patient Application" form described in (c) below.

(b) The "Minor Patient Application" form shall be a combined application for both the minor applicant and the designated caregiver applicant(s).

(c) The minor applicant's custodial parent(s) or legal guardian shall include the following on the "Minor Patient Application":

(1) Indication whether it is an initial or renewal application, and if an initial application, whether the criminal record authorization form and fee have been sent to the NH department of safety;

(2) The following minor applicant information:

a. Full name;

b. Date of birth;

c. Gender;

d. Mailing address; and

e. Physical address, if different than mailing address, except that if the minor applicant is experiencing homelessness this shall not be required;

(3) The following information about the designated caregiver applicant(s):

a. Full name;

b. Date of birth;

c. Gender;

d. Phone number

e. Optional e-mail address;

f. Mailing address, if different than the minor applicant; and

g. Physical address, if different than the minor applicant;

(4) The following information about the minor applicant's certifying providers:

a. First and last name;

b. Business address; and

c. Telephone number;

(5) A signed and dated release authorizing the release of relevant medical information by the certifying providers to the department if further information about the minor applicant's qualifying medical condition or written certification is required by the department;

(6) The name and city or town of the designated ATC;

(7) Signed and dated attestation(s) of the following minor patient requirements:

a. "I am the custodial parent or legal guardian responsible for the health care decisions of the applicant.";

b. "The applicant's certifying providers have explained to me the potential risks and benefits of the therapeutic use of cannabis.";

c. "I consent to allow the applicant's therapeutic use of cannabis.";

d. "I consent to serve as the applicant's Designated Caregiver and to control the acquisition of cannabis and the frequency of the therapeutic use of cannabis by the applicant.";

e. "I understand that if I am not approved to be a Designated Caregiver, then the applicant's application to be a Qualifying Patient shall not be approved."; and

f. If applicable, "I share legal custody of the applicant, and I have notified the other parent or guardian with legal custody of the applicant in advance of submitting this application by having provided to the other parent or guardian a copy of the completed Application form and the completed Written Certification forms.";

(8) Signed and dated attestation(s) of the following acknowledgements:

a. "I understand that Registry ID Cards are valid for one year, unless a shorter duration is indicated. Cards must be renewed every year by submitting another application and fee.";

b. "I understand that if I am notified of a denial, I have 30 days to appeal this decision from the date of the denial notice, and that if a request for a hearing is not made within that timeframe then I will be deemed to have waived my right to a hearing and the action of the Department shall become final.";

c. "I understand that I may not possess, between myself and my Qualifying Patient(s), more than two ounces of usable cannabis per Qualifying Patient.";

d. "I understand that as a Designated Caregiver I am not permitted to use therapeutic cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so.";

e. "I understand that my Qualifying Patient may only use therapeutic cannabis for the purpose of treating or alleviating their qualifying medical condition.";

f. "I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X.";

g. "I understand that my Qualifying Patient may not be under the influence of therapeutic cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in their place of employment, without the written permission of the employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.";

h. "I understand that my Qualifying Patient may not smoke or vaporize therapeutic cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field.";

i. "I understand that my Qualifying Patient and I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.";

j. "I understand that my Qualifying Patient may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property.";

k. "I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Program of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV.";

l. "I understand that if my Qualifying Patient or I am found to be in possession of therapeutic cannabis outside of our home and we are not in possession of a Registry ID Card, we may be subject to a fine of up to $100.";

m. "I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.";

n. "I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within NH.";

o. "I understand that my Qualifying Patient and I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke a Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder."; and

p. "I understand that I, by possessing therapeutic cannabis, and my Qualifying Patient, by using therapeutic cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.";

(9) Signed and dated certification(s) that:

a. The minor applicant is a resident of New Hampshire;

b. The facts as stated in the application are accurate to the best of the designated caregiver applicant's knowledge and belief; and

c. The designated caregiver applicant understands that any false statements made on the application are punishable as unsworn falsification under RSA 641:3;

(10) A signed and dated pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, ~~and~~ acknowledgement that diversion of cannabis ~~is punishable as a class B felony and~~ shall result in revocation of their registry identification card, and acknowledgement that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis; and

(11) Voluntary demographic information, as follows:

a. For the minor applicant, race and ethnicity; and

b. For the designated caregiver applicant(s):

1. Race and ethnicity;

2. Veteran status;

3. Employment and income;

4. Public assistance;

5. Education;

6. Health insurance;

7. Marital status; and

8. Language proficiency.

(d) In cases where parents share legal custody of a minor applicant, and both parents are not listed on the application, the parent submitting an application shall notify the other parent with legal custody of the minor applicant in advance of submitting the application to the department by providing to the other parent a copy of the completed application and the completed written certifications.

(e) In addition to the application described in (c) above, the following shall also be submitted:

(1) Two written certifications, described in He-C 401.07, from 2 different providers, one of whom shall be a pediatrician;

(2) Proof of NH residency, as described in He-C 401.04(b)(3), for either the minor applicant or one of the designated caregiver applicants;

(3) A fee in accordance with He-C 401.14(b)(2); and

(4) In cases where a minor applicant's legal guardian is not a custodial parent, the legal guardian shall submit with the application proof of legal guardianship.

(f) In addition to the materials in (c) and (e) above, for each designated caregiver applicant the department shall also receive the results of a state and federal criminal history records check from the division of state police, department of safety, as described in He-C 401.05(d) and (e). An application shall not be considered complete without the results of a state and federal criminal history records check.

(g) The documents in (c) and (e) above shall be submitted to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301

Note to Agency. Remember to include the repealed struck-through text in the filed adopted rule

Repeal He-C 401.09, effective 11-2-15 (Document #10646), as amended effective 11-2-15 (Document #10964), as follows:

~~He-C 401.09 Approval of a Severely Debilitating or Terminal Medical Condition Not Listed as a Qualifying Medical Condition.~~

~~(a) A provider may request the department to include a medical condition not listed in He-C 401.02(j)(1) and RSA 126-X:1, IX(a)(1):~~

~~(1) If the medical condition, or the treatment thereof, is severely debilitating or terminal;~~

~~(2) If the medical condition, or the treatment thereof, manifests in one or more of the symptoms included in He-C 401.02(j)(2) and RSA 126-X:1, IX(a)(2); and~~

~~(3) By submitting a written petition to the department for consideration.~~

~~(b) The department shall accept petitions in the months of January and July of each year, beginning in January 2017.~~

~~(c) The department shall consider a petition only if it includes the following information:~~

~~(1) A detailed justification for including a new medical condition as a qualifying medical condition;~~

~~(2) A description of the extent to which the medical condition is generally accepted by the medical community as a valid, existing medical condition, and is considered severely debilitating or terminal;~~

~~(3) If one or more treatments for the condition, rather than the condition itself, are alleged to be the cause of suffering, a description of the extent to which the treatments causing suffering are generally accepted by the medical community as valid treatments for the condition;~~

~~(4) A description of the symptoms caused by the condition or treatments thereof and the extent to which the condition or the treatments thereof cause elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options~~

~~produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms. Such symptoms may be either related to a specific patient or those typically experienced by patients who have the condition or are receiving treatments therefor;~~

~~(5) A description of the availability, or lack thereof, of conventional medical treatments, other than those that cause suffering, to alleviate suffering caused by the condition or the treatment thereof;~~

~~(6) A description of the extent to which evidence that is generally accepted among the medical community and other experts supports a finding that the use of cannabis alleviates suffering caused by the condition or the treatment thereof; and~~

~~(7) A description of any information or studies known to the petitioner regarding health effects, including any beneficial or adverse effects, from the use of cannabis in patients with the medical condition that is the subject of the petition.~~

~~(d) Information contained in a petition that identifies a specific patient or patients shall be confidential and exempt from disclosure under RSA 91-A.~~

~~(e) If a medical condition in a petition has been previously considered and rejected by the department, the department shall not accept the petition for further consideration unless the petition contains new scientific evidence or research, or describes substantially different symptoms, not previously considered in an earlier petition.~~

~~(f) The department shall provide written notice to the petitioner whether the petition is accepted or rejected for consideration.~~

~~(g) The department shall conduct a public hearing to evaluate any petitions it has accepted.~~

~~(h) No less than 20 days before each public hearing, the department shall provide notice of such hearing by publishing on its Internet website the date, time and location of the hearing, and the medical condition(s) that will be considered.~~

~~(i) In addition to information provided in a petition and at the public hearing, the department shall consider scientific, medical or other evidence and research pertaining to the petition, and shall consider information provided, in person or in writing, from other persons knowledgeable about the medical condition from within and without the department, including members of the therapeutic cannabis advisory council, as established pursuant to RSA 126-X:9.~~

~~(j) Following the public hearing, the department shall consider the petition, the public comments, and any additional information or expertise described in (i) above for each proposed medical condition considered at the hearing.~~

~~(k) Within 120 days of the receipt of a petition accepted by the department for consideration, the department shall issue a written decision about each medical condition for which a petition was accepted for consideration.~~

~~(l) The department shall include in the written decision the following:~~

~~(1) Matters that the department considers relevant to the decision made about the petition; and~~

~~(2) Whether the medical condition will now be included as a qualifying medical condition for the therapeutic use of cannabis.~~

~~(m) A medical condition that has been approved by the department as a qualifying medical condition for the therapeutic use of cannabis in accordance with (a) through (k) above shall be available to all individuals who apply for a registry identification card as a qualifying patient.~~

~~(n) A petitioner may appeal a denial of the petition to the commissioner by submitting a request for an appeal within 30 days of the issuance of a decision.~~

~~(o) Pursuant to RSA 126-A:5, VIII(c)-(e), the commissioner shall not delegate, but shall retain, his or her decision making authority on all appeals made under this section.~~

Adopt He-C 401.09 to read as follows:

He-C 401.09 Initial Application Requirements for Adult Patients with Guardians.

(a) The patient applicant's legal guardian who is responsible for the health care decisions of the patient applicant shall complete and submit the "Guardianship Patient Application" form described in (c) below.

(b) The "Guardianship Patient Application" form shall be a combined application for both the patient applicant and the designated caregiver applicant(s).

(c) The patient applicant's legal guardian shall include the following on the "Guardianship Patient Application" form:

(1) Indication whether it is an initial or renewal application, and if an initial application, whether the caregiver applicant submitted the criminal record authorization form and fee to the NH department of safety;

(2) The following patient applicant information:

a. Full name;

b. Date of birth;

c. Gender;

d. Optional telephone number;

e. Optional e-mail address;

f. Mailing address; and

g. Physical address, if different than mailing address, except that if the patient applicant is experiencing homelessness this shall not be required;

(3) The following information about the designated caregiver applicant(s):

a. Full name;

b. Date of birth;

c. Gender;

d. Phone number

e. Optional e-mail address;

f. Mailing address, if different than the patient applicant; and

g. Physical address, if different than the patient applicant;

(4) The following information about the patient applicant's certifying provider:

a. First and last name;

b. Business address; and

c. Telephone number;

(5) A signed and dated release authorizing the release of relevant medical information by the certifying provider to the department if further information about the patient applicant's qualifying medical condition or written certification is required by the department;

(6) The name and city or town of the designated ATC;

(7) Signed and dated attestation(s) of the following acknowledgements:

a. "I understand that Registry ID Cards are valid for one year, unless a shorter duration is indicated. Cards must be renewed every year by submitting another application and fee.";

b. "I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.";

c. "I understand that I may not possess, between myself and my Qualifying Patient, more than two ounces of usable cannabis per Qualifying Patient.";

d. "I understand that as a Designated Caregiver I am not permitted to use therapeutic cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so.";

e. "I understand that my Qualifying Patient may only use therapeutic cannabis for the purpose of treating or alleviating their qualifying medical condition.";

f. "I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X.";

g. "I understand that my Qualifying Patient may not be under the influence of therapeutic cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in their place of employment, without the written permission of the employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.";

h. "I understand that my Qualifying Patient may not smoke or vaporize therapeutic cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field.";

i. "I understand that my Qualifying Patient and I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.";

j. "I understand that my Qualifying Patient may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property.";

k. "I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Department of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV.";

l. "I understand that if my Qualifying Patient or I am found to be in possession of therapeutic cannabis outside of our home and we are not in possession of a Registry ID Card, we may be subject to a fine of up to $100.";

m. "I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.";

n. "I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within New Hampshire.";

o. "I understand that my Qualifying Patient and I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke a Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder."; and

p. "I understand that I, by possessing therapeutic cannabis, and my Qualifying Patient, by using therapeutic cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.";

(8) Signed and dated certification(s) that:

a. The patient applicant is a resident of New Hampshire;

b. The facts as stated in the application are accurate to the best of the designated caregiver applicant's knowledge and belief; and

c. The designated caregiver applicant understands that any false statements made on the application are punishable as unsworn falsification under RSA 641:3;

(9) Signed and dated pledge(s) not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, ~~and~~ acknowledgement that diversion of cannabis ~~is punishable as a class B felony and~~ shall result in revocation of their registry identification card, and acknowledgement that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis; and

(10) Voluntary demographic information, as follows:

a. Race and ethnicity;

b. Veteran status;

c. Employment and income;

d. Public assistance;

e. Education;

f. Health insurance;

g. Marital status; and

h. Language proficiency.

(d) In cases where co-guardians share legal custody of an adult patient applicant, and both co-guardians are not listed on the application, the guardian submitting an application shall notify the other guardian with legal custody of the adult patient applicant in advance of submitting the application to the department by providing to the other guardian a copy of the completed application and the completed written certification.

(e) In addition to the application described in (c) above, the following shall also be submitted:

(1) A written certification, described in He-C 401.07;

(2) Proof of NH residency for the patient applicant, as described in He-C 401.04(b)(3), except that if this information is not available for the patient applicant, it shall be submitted for one of the designated caregiver applicants;

(3) A fee in accordance with He-C 401.14(b)(5); and

(4) Proof of legal guardianship for each designated caregiver applicant listed on the application.

(f) In addition to the materials in (c) and (e) above, for each designated caregiver applicant the department shall also receive the results of a state and federal criminal history records check from the division of state police, department of safety, as described in He-C 401.05(d) and (e). An application shall not be considered complete without the results of a state and federal criminal history records check.

(g) The documents in (c) and (e) above shall be submitted to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301

Note to JLCAR. The program has its own application timeline requirements pursuant to RSA 126-X:4, III that are stricter than those found at RSA 541-A:29 with the exception of an incomplete application. In that case, these rules permit the applicant to supply the missing information within 6 months or the application shall be closed.

Readopt with amendment He-C 401.10, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.10 Processing of Applications and Issuance of Registry Identification Cards.

(a) An application for initial approval as a qualifying patient or a designated caregiver shall be complete when the department determines that all information and supporting documentation required by He-C 401.04, He-C 401.05, He-C 401.06, He-C 401.08, or He-C 401.09 have been received.

(b) If an application does not contain all of the items required by He-C 401.04, He-C 401.05, He-C 401.06, He-C 401.08, or He-C 401.09 the department shall notify the applicant, and the applicant's certifying provider in the case of a written certification, in writing within 10 days specifying any information or supporting documentation required to be submitted before the application can be processed.

(c) If after written notice in (b) above the applicant, or the applicant's provider in the case of a written certification, fails to provide the missing information or supporting documentation, including payment of the required fee, within 30 days of such notice, the application shall be considered incomplete.

(d) If the missing information or supporting documentation, including payment of the required fee, is not received within 6 months of the notice, the application shall be considered closed, and that applicant may reapply by re-submitting all required application materials, including the required fee(s), anew.

(e) The department shall approve an applicant as a qualifying patient if the department determines that:

(1) The applicant has submitted to the department a complete application and the required supporting documentation in accordance with He-C 401.04;

(2) The applicant is a resident of New Hampshire;

(3) The applicant's provider has completed a written certification that meets the requirements of He-C 401.07 and has certified that the applicant has a qualifying medical condition which meets the definition in He-C 401.02(j);

(4) All information submitted is accurate;

(5) No basis for denial, as established in He-C 401.12(a), exists;

(6) In the case of a minor patient, all requirements in He-C 401.08 have been met; and

(7) In the case of an adult patient with guardian(s), all requirements in He-C 401.09 have been met.

(f) The department shall approve an applicant as a designated caregiver if the department determines that:

(1) The applicant has submitted to the department a complete application and required supporting documentation in accordance with He-C 401.05;

(2) The applicant is at least 21 years old;

(3) Based upon the results of the criminal history records check or the police clearances received, the applicant has never been convicted of a felony;

(4) The qualifying patient(s) listed on the caregiver application has designated the caregiver applicant as the qualifying patient's caregiver;

(5) The number of qualifying patients listed on the caregiver application does not exceed 5, except that additional qualifying patients shall be allowed, up to a maximum of 9, if both the designated caregiver and the additional qualifying patients each live greater than 50 miles from the nearest ATC;

See note to JLCAR on the top of page 26.

(6) All information submitted is accurate; and

(7) No basis for denial, as established in He-C 401.12(a), exists.

(g) Pursuant to RSA 126-X:4, III, the department shall act on a complete application, including all supporting documentation and the required fee, for either a qualifying patient or a designated caregiver within 15 calendar days of its receipt. This timeframe shall not apply to applications that are determined to be incomplete.

(h) Within 5 calendar days of the determination to approve an application for either a qualifying patient or a designated caregiver, the department shall issue to the applicant a registry identification card.

(i) The department shall send notice of the qualifying patient's approval to the patient's certifying provider, including:

(1) The expiration date of the patient's registry identification card;

(2) The name of and contact information for the ATC the patient has designated; and

(3) Information about providing recommendations or instructions to the ATC regarding the patient's therapeutic use of cannabis, described in He-C 401.06(b)(9).

Readopt with amendment He-C 401.11 through He-C 401.13, effective 11-2-15 (Document #10646), as amended effective 11-2-15 (Document #10964), to read as follows:

He-C 401.11 Registry Identification Card Expirations, Exceptions, and Procedures for Renewals.

(a) A registry identification card shall be valid on the date of issuance and expire one year later on the last day of the month it was issued unless a shorter time period is established in accordance with (d) below.

(b) To renew a registry identification card and prevent a possible lapse in registration, each qualifying patient and designated caregiver shall complete and submit to the department application materials pursuant to He-C 401.04, He-C 401.05, He-C 401.08, or He-C 401.09 at least 30 days prior to the expiration of their current registry identification card, except that:

Unclear/Edit. The Department indicated that it has been using the form as adopted in the last rulemaking with an edition date of Oct. 2015. The new form as submitted with the IP had edition date of 3/20. Since the intent is to incorporate this form by reference, insert the edition date after "form".

(1) For designated caregivers, the criminal history records check results required by He-C 401.05(c) shall not be required, but the designated caregiver shall complete, sign under penalties set forth in RSA 641:3 for unsworn falsification, date, and submit a "Designated Caregiver's Attestation of No Felony Conviction" form, which states that the individual has not been convicted of a felony offense in New Hampshire or any other state, provided there has not been a lapse in registration of more than one year;

(2) For qualifying patients who have not changed their mailing address or physical address, proof of NH residency required by He-C 401.04(b)(3) shall not be required; and

(3) For qualifying patients who have guardians, guardianship documentation required by He-C 401.08(e)(4) and 401.09(e)(4) shall not be required, regardless of any lapse in registration, unless there has been a change in guardianship.

(c) Applications for renewal shall be processed and registry identification cards shall be issued in accordance with He-C 401.10.

(d) Exceptions to (a) above shall be as follows:

(1) If the qualifying patient's certifying provider indicates on the written certification that the certification should be valid for a shorter duration, then the registry identification card shall be valid for the shorter duration indicated, subject to extension in accordance with He-C 401.06(h);

(2) If the qualifying patient's certifying provider rescinds or otherwise withdraws the patient's written certification pursuant to He-C 401.06(f) and (g), the registry identification card shall become void upon notification by the department to the qualifying patient;

(3) A designated caregiver's registry identification card shall be deactivated upon notification by the department to the designated caregiver that all the qualifying patients for whom the individual is acting as designated caregiver either have lost their status as qualifying patients or have rescinded or otherwise ended the designation, subject to reactivation in accordance with He-C 401.13(k); and

(4) If an applicant's payment is returned for insufficient funds, and the applicant does not remit full payment in accordance with RSA 6:11-a within 10 days of the department's written notice:

a. The registry identification card shall be deactivated, subject to reactivation upon receipt of full payment within 6 months of the notice; and

b. After 6 months, the case shall be considered closed, and that applicant may reapply by submitting all required application materials, including the required fees.

He-C 401.12 Denial of an Application, Enforcement Actions, and Administrative Appeals.

(a) The department ~~may~~ shall deny an initial or renewal application for a registry identification card if:

(1) The applicant previously had a registry identification card revoked for violating the provisions of RSA 126-X or He-C 401;

(2) The department determines that the information provided in the application or supporting material was misleading, false, or fraudulent;

(3) The applicant previously had a registry identification card denied for providing in the application or supporting material information that was determined to be misleading, false, or fraudulent;

(4) The department determines that the information provided in the application or supporting documentation did not meet the requirements of RSA 126-X or He-C 401;

(5) A minor applicant's custodial parent or legal guardian is not approved to be a designated caregiver, except that if both parents are listed on the minor patient application as designated caregivers, and only one designated caregiver applicant is denied, the minor patient's application to be a qualifying patient shall not be denied; or

(6) A legal guardian of an adult applicant with a guardian is not approved to be a designated caregiver, except that if co-guardians are listed on the adult guardianship application as designated caregivers, and only one designated caregiver applicant is denied, the patient's application to be a qualifying patient shall not be denied.

(b) The department shall revoke a qualifying patient or designated caregiver's registry identification card for any of the following:

(1) Violation of any provision of RSA 126-X or He-C 401;

(2) Submission of misleading, false, or fraudulent information in the application or supporting documentation;

(3) Fraudulent use of a registry identification card;

(4) Selling, distributing, or giving cannabis to any unauthorized person;

(5) Tampering, falsifying, altering, modifying, duplicating, or allowing another person to use, tamper, falsify, alter, modify, or duplicate a registry identification card;

(6) A designated caregiver has been convicted of a felony in this or any other state;

(7) A qualifying patient or designated caregiver is an inmate at a correctional facility;

(8) A qualifying patient is no longer a resident of New Hampshire;

(9) A qualifying patient used cannabis in a manner that puts others at risk of their health, safety, or welfare, or has failed to take reasonable precautions to avoid putting others at such risk; and

(10) A qualifying patient or designated caregiver produces cannabis concentrate using an extraction method that is prohibited by He-C 401.18.

(c) At the time of denying an application for a registry identification card or revoking a registry identification card, the department shall send to the applicant or cardholder written notice that sets forth:

(1) The action to be taken by the department;

(2) The reason(s) for the action; and

(3) The right of an applicant or cardholder to a hearing in accordance with He-C 200 before the enforcement action becomes final.

(d) An applicant or cardholder shall have 30 days from the date of the notice of the enforcement action to request a hearing to contest the action.

(e) If a request for a hearing is not made pursuant to (d) above, the applicant or cardholder shall be deemed to have waived their right to a hearing.

(f) Hearings under this section shall be conducted in accordance with He-C 200.

He-C 401.13 Requirements for Notifications.

(a) A qualifying patient shall notify the department in writing of any of the following:

(1) A change to the qualifying patient's name or address, within 10 days of such change;

(2) The designation of a caregiver if the patient has not already done so on an initial or renewal application, the removal of a designated caregiver, or both;

(3) A change to the qualifying patient's designated ATC; or

(4) A registry identification card has been lost, stolen, or destroyed, within 10 days of the discovery of the loss, theft, or destruction.

(b) A designated caregiver shall notify the department in writing of any of the following:

(1) A change to the designated caregiver's name or address, within 10 days of such change;

(2) A change to the designated caregiver's qualifying patient(s);

(3) A registry identification card has been lost, stolen, or destroyed, within 10 days of the discovery of the loss, theft, or destruction; or

(4) Immediately upon being convicted of a felony in this or any other state.

(c) The notifications in (a)(1), (3), and (4) and (b)(1) and (3) above may be on a "Change of Information / Lost Card" form, which shall include the following information:

(1) Name, date of birth, and phone number;

Unclear/Public Interest. The form "Change of information/Lost card" as submitted with the IP had an edition date of 3/20. The JLCAR may have questions about whether the forms were required prior to approval.

Unclear/Public Interest. This form "Caregiver Designation/Removal" as submitted with the IP had an edition date of 3/20. The JLCAR may have questions about whether the forms were required prior to approval.

(2) For a name or address change, the new name, address, or both;

(3) For change of ATC, the current ATC and the new ATC; and

(4) For a replacement registry identification card, indication that a registry identification card has been lost, stolen, or destroyed, and the submission of the required fee pursuant to He-C 401.14(b)(4).

(d) The notifications in (a)(2) and (b)(2) above may be on a "Caregiver Designation / Removal" form, which shall include the following information, as applicable:

(1) To be completed by the qualifying patient:

a. The qualifying patient's name, date of birth, and registry identification card number;

b. The name of the person(s) being designated, removed, or both, as the qualifying patient's designated caregiver; and

c. The qualifying patient's dated signature; and

(2) To be completed by the designated caregiver:

a. The designated caregiver's name and date of birth;

b. Acceptance of the designation to act as a caregiver for the qualifying patient listed in (1)a. above;

c. Indication that the caregiver is either:

1. Currently a designated caregiver, and the current registry identification card number; or

2. Not currently a designated caregiver, and that the individual understand that a separate and complete caregiver application must be submitted to the department;

d. Indication that the designated caregiver shall no longer serve as designated caregiver for the qualifying patient listed on the form; and

e. The designated caregiver's dated signature.

(e) If a qualifying patient's certifying provider provides written notice to the department pursuant to He-C 401.06(f) and (g) to rescind or otherwise withdraw a written certification which the provider previously issued, the qualifying patient's:

(1) Application shall be considered incomplete if the registry identification card has not yet been issued, and the applicant shall be issued a refund of the application fee; or

(2) Registry identification card shall become void upon notification by the department to the qualifying patient.

(f) Upon learning of the death of a qualifying patient, a surviving family member, caretaker, executor, or the qualifying patient's designated caregiver shall:

(1) Notify the department that the qualifying patient has died, within 5 days of the death; and

(2) Within 5 days of the death, dispose of any remaining cannabis by either:

a. Requesting a local law enforcement agency to remove the remaining cannabis; or

b. Mixing the remaining cannabis with other ingredients such as soil to render it unusable.

(g) As applicable, the department shall notify a qualifying patient or designated caregiver of any changes described in (a) through (f) above regarding their designated caregiver or qualifying patient, respectively.

(h) A new registry identification card shall be issued within 20 days for any change to a qualifying patient's or designated caregiver's name or address.

(i) If a qualifying patient or designated caregiver loses their registry identification card, whether due to loss, theft, or destruction:

(1) They shall notify the department in writing within 10 days of losing the card;

(2) They shall submit payment of a fee pursuant to RSA 126-X:4, IX(f), and He-C 401.14(b)(4) if they want a replacement card; and

(3) Within 5 days of such notification and payment, the department shall issue a new registry identification card.

(j) A designated caregiver's registry identification card shall become void upon notification by the department to the designated caregiver that all the qualifying patients for whom the individual is acting as designated caregiver either have lost their status as qualifying patients or have rescinded or otherwise ended the designation.

(k) A voided registry identification card in (j) above shall be reactivated if a new qualifying patient designates the caregiver, and the designated caregiver accepts that designation, within the designated caregiver's current registration period.

(l) A registry identification card that is outdated, has expired, has been voided, except in the case of (j) above, or has been revoked shall be destroyed by the cardholder.

Readopt with amendment He-C 401.14 through He-C 401.16, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.14 Schedule and Payment of Fees.

Note to JLCAR. RSA 126-X:4 provides that the Department shall establish fees and fines for the Therapeutic Cannabis Program, and RSA 126-X: 6, II directs the Department to establish the registry fees but did not specify or cap those fees.

(a) All fees required by this section shall be paid as follows:

(1) By check or money order for the exact amount of the fee or fine made payable to "Treasurer – State of New Hampshire";

(2) A money order or certified check shall be required when payment has been made to the department by check, and such check was returned for insufficient funds; and

(3) Any payment submitted to the department in the form of a check or money order and returned to the state for any reason shall be processed in accordance with RSA 6:11-a.

(b) The department shall charge the following fee amounts:

(1) For a qualifying patient's initial and renewal application, as required by He-C 401.04(b)(2), the fee shall be $50;

(2) For an initial or renewal application for a minor patient, as required by He-C 401.08(e)(3), the fee shall be $50, even if there are 2 designated caregiver applicants;

(3) For an initial or renewal application for a guardianship patient, as required by He-C 401.09(e)(3), the fee shall be $50, even if there are 2 designated caregiver applicants; and

(4) For issuance of a replacement registry identification card due to loss, theft, or destruction, pursuant to He-C 401.13(i), the fee shall be $10.

(c) There shall be no fee for an application to become a designated caregiver.

(d) In the case of (b)(2) and (b)(3) above, there shall be no additional fee if the second designated caregiver is added after the patient has been approved and been issued a registry identification card.

(e) All fees shall be non-refundable.

(f) Notwithstanding (e) above, the department shall issue a refund of an application fee if:

(1) Informed that the patient applicant has died before the registry identification card has been issued; or

(2) A written certification is withdrawn by the certifying provider in accordance with He-C 401.13(e) before the registry identification card has been issued.

He-C 401.15 Confidentiality.

(a) The department shall maintain the confidentiality of all information about applicants, qualifying patients, designated caregivers, certifying providers, and ATCs that is contained in the department's registry, as provided by RSA 126-X, He-C 400, and the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR 160, 162 and 164, as applicable.

(b) Notwithstanding (a) above, information in (a) above shall be used and disclosed by the department to:

(1) Authorized employees of the department in the course of their official duties;

(2) An individual or entity pursuant to an order from a court of competent jurisdiction;

(3) Law enforcement personnel in accordance with RSA 126-X:4, XI(b)(1)-(3), but such information shall be limited to:

a. The location associated with a qualifying patient, designated caregiver, or ATC; and

b. Whether a person is a qualifying patient or a designated caregiver;

(4) Law enforcement personnel in accordance with RSA 126-X:4, XI(b)(5), regarding information related to falsified or fraudulent information submitted to the department where counsel has made a legal determination that there is probable cause to believe the information is false or falsified;

(5) The NH board of medicine, the NH board of nursing, or the appropriate regulatory entity in Maine, Massachusetts, or Vermont, pursuant to RSA 126-X:4, VII(c), and RSA 126-X:2, VIII, but such information shall be related to the conveyance of concerns regarding provider conduct;

(6) The health and human services oversight committee established under RSA 126-X:13, to the NH board of medicine, and the NH board of nursing in the department's annual data report required by RSA 126-X:10, except that only deidentified, aggregate data required by RSA 126-X:10, IV, shall be released;

(7) To a qualifying patient, a qualifying patient's certifying provider, or a qualifying patient's designated caregiver for the purposes of carrying out these rules;

(8) To an individual or entity pursuant to a release signed by the qualifying patient, designated caregiver, certifying provider, or authorized ATC agent; and

(9) Individuals or entities for the purposes of public health, health care operations, or research if such release is consistent with all applicable HIPAA standards, pursuant to RSA 126-X:10, VI.

(c) In order for information to be disclosed to law enforcement personnel in accordance with (b)(3) above, the following shall have occurred:

(1) Local or state law enforcement personnel shall have detained or arrested an individual who claims to be engaged in the therapeutic use of cannabis;

(2) A local or state law enforcement officer shall have submitted a sworn affidavit to the department affirming that they have probable cause to believe cannabis is possessed at a specific address; or

(3) A local or state law enforcement officer shall have submitted a sworn affidavit to the department affirming that they have probable cause to believe a specific individual possesses cannabis, and has also provided the person's name and address or name and date of birth.

(d) In accordance with RSA 126-X:4, II-a, the department shall maintain the confidentiality of all criminal history records information received.

He-C 401.16 Visiting Qualifying Patients.

(a) For a visiting qualifying patient, "provider" means, pursuant to RSA 126-X:1, VII(b), "an individual licensed to prescribe drugs to humans in the state of the patient's residence and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances."

(b) Pursuant to RSA 126-X:2, V, a valid registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth, or insular possession of the United States that allows, in the jurisdiction of issuance, a visiting qualifying patient to possess cannabis for therapeutic purposes, shall have the same force and effect as a valid registry identification card issued by the department in this state, provided that:

(1) The visiting qualifying patient shall also produce a statement from their provider stating that the visiting qualifying patient has a qualifying medical condition as defined in RSA 126-X:1, IX; and

(2) A visiting qualifying patient shall not cultivate or purchase cannabis in New Hampshire or obtain cannabis from ATCs or from a qualifying patient or designated caregiver.

Readopt He-C 401.17 and He-C 401.18, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.17 Waivers.

(a) An individual seeking waivers of specific rules in He-C 401 shall submit a written request for a waiver to the department that includes:

(1) The specific reference to the rule for which a waiver is being sought;

(2) A full explanation of why a waiver is necessary;

(3) A full explanation of alternatives proposed, which shall be equally as protective of public and patient health and safety as the rule from which a waiver is sought; and

(4) The period of time for which the waiver is sought.

(b) Waivers shall not exceed 12 months, or the current registry identification card expiration date.

(c) A request for waiver shall be granted if the department determines that the alternative proposed by the applicant or licensee:

(1) Meets the objective or intent of the rule for which the waiver is sought; and

(2) Does not negatively impact the health or safety of any qualifying patient or the public.

(d) The individual's subsequent compliance with the alternatives approved in the waiver shall be considered equivalent to complying with the rule from which waiver was sought.

(e) No provision or procedure prescribed by statute shall be waived.

Readopt with amendment He-C 401.18, effective 11-2-15 (Document #10646), to read as follows:

He-C 401.18 Production of Cannabis-Infused Products. A qualifying patient or designated caregiver may produce cannabis concentrate only through either a food or water-based extraction method. All other extraction methods shall be prohibited.

Note to JLCAR on the public hearing: The rulemaking public hearing for this proposal was to be held on 1/26/21 as an in-person public hearing and included remote options (telephonic and Microsoft Teams). RSA 541-A:11 presumes in person public hearings and does not address remote public hearings or their requirements. The Governor's E.O. #12 amends RSA 91-A to allow for remote public hearings, but it does not apply to departments or rulemaking proceedings under RSA 541-A. The JLCAR may wish to ask how the remote option worked out, and may want to consider legislation to not only affirmatively address language in RSA 541-A: 11 that presumes in person public hearings, but also to require a remote public hearing option during global pandemics and to outline their requirements. In the meantime, SB 95 contains an amendment to RSA 91-A to address the protocols of remote meetings by public bodies contained in the Governor's E.O. #12 but not to address rulemaking hearings under RSA 541-A:11.

APPENDIX

RULE	STATUTE
He-C 401.01	RSA 126-X
He-C 401.02	RSA 126-X:1
He-C 401.03	RSA 126-X:2, IV(a)-(b); RSA 126-X:3, V
He-C 401.04	RSA 126-X:4, I
He-C 401.04(a)(7)n.	RSA 126-X:4, VI
He-C 401.04(a)(9)	RSA 126-X:4, I(h); RSA 126-X:3, VI; RSA 318-B:26, IX-a
He-C 401.04(b)(3)	RSA 126-X:1, X
He-C 401.05	RSA 126-X:4, II
He-C 401.05(a)(3)	RSA 126-X:1, VI(b)
He-C 401.05(a)(4)l.	RSA 126-X:4, VI
He-C 401.05(a)(6)	RSA 126-X:5, II(f); RSA 126-X:3, VI; RSA 318-B:26, IX-a
He-C 401.05(b)-(d)	RSA 126-X:4, II-a
He-C 401.06	RSA 126-X:1, VII(a), VIII, XVII
He-C 401.06(b)(4)a.	RSA 310-A:1-g
He-C 401.06(b)(5)b.	RSA 126-X:4, V(b)
He-C 401.06(e)	RSA 126-X:8, XVIII
He-C 401.06(f)-(g)	RSA 126-X:4, IX(b)
He-C 401.07	RSA 126-X:1, XVII
He-C 401.07(c)(3)b.	RSA 126-X:4, V(b)
He-C 401.07(b)(6)	RSA 126-X:4, IV
He-C 401.08	RSA 126-X:4, I, II, II-a, and V
He-C 401.08(c)(10)	RSA 126-X:5, II(f); RSA 126-X:3, VI; RSA 318-B:26, IX-a
He-C 401.09	RSA 126-X:4, I, II, and II-a
He-C 401.08(c)(9)	RSA 126-X:5, II(f); RSA 126-X:3, VI; RSA 318-B:26, IX-a
He-C 401.10	RSA 126-X:4, I-IV
He-C 401.11	RSA 126-X:4, I-IV
He-C 401.11(e)(2)	RSA 126-X:4, IX(b)
He-C 401.12	RSA 126-X:4, III; RSA 126-X:3, VI-VII; RSA 126-X:6, I(c)
He-C 401.13	RSA 126-X:4, IX
He-C 401.13(f)	RSA 126-X:4, XII; RSA 126-X:2, XIV(b)-(c)
He-C 401.14	RSA 126-X:4, I(b); RSA 126-X:6: I(d); RSA 126-X:4, IX(f)
He-C 401.15	RSA 126-X:4, XI; RSA 126-X:10, VI
He-C 401.15(b)(5)	RSA 126-X:4, VII(a)(2)
He-C 401.15(b)(6)	RSA 126-X:10
He-C 401.15(d)	RSA 126-X:4, II(g)
He-C 401.16	RSA 126-X:1, XVI; RSA 126-X:1, VII(b); RSA 126-X:2, V
He-C 401.17	RSA 541-A:22, IV
He-C 401.18	RSA 126-X:6, I(c)

Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

29 HAZEN DRIVE, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
email: TCP@dhhs.nh.gov

PATIENT APPLICATION

For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

Information about the Therapeutic Cannabis Program, including the law (RSA 126-X), the rules (He-C 400), and all required forms, is available on the Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

1. Read the "General Program Information" at the end of this application packet.
2. Complete ALL information on pages 1 and 3. Complete page 2 if you want to designate a caregiver or if you want to provide voluntary demographic information.
3. **Submit with this Application Form**:
   a. A separate "Written Certification for the Therapeutic Use of Cannabis" form completed by your medical provider.
   b. Proof of New Hampshire residency.* Submit ONE of the following:
      - A copy of your New Hampshire driver's license or New Hampshire State ID (front only); OR
      - Any other documentation that contains your name and current NH address, such as a current lease agreement or vehicle registration, or a utility bill, medical bill, property tax bill, mortgage statement, bank statement, government check, or payroll check with a date showing that it was issued within the previous 6 months; OR
      - Other state or federal government-issued identification that shows your name and NH address.

      Original documents are not required; legible photocopies of original documents are acceptable and preferred.

      **Proof of residency is not required for renewal applications if there has not been a change of address.*
   c. A $50 application fee:
      - A check or money order made payable to "Treasurer, State of New Hampshire" in the amount of $50.
      - The Program cannot accept cash, credit cards, or installment payments.
4. Mail or hand-deliver the following:

Required Documents:	To This Address:
☐ A completed Patient Application ☐ A completed Written Certification (from your provider) ☐ Proof of NH residency (see 3b above) ☐ Application fee (see 3c above)	NH Department of Health and Human Services Therapeutic Cannabis Program 29 Hazen Drive Concord, NH 03301

5. Application processing:
   a. Application processing takes up to 3 weeks.
      - The Program will approve or deny a complete application within 15 days of receipt.
      - The Program will issue a Registry ID Card within 5 days of approval.
   b. Incomplete applications:
      - You will be notified in writing within 10 days if an application is incomplete.
      - You will be asked to submit the missing information/documentation within 30 days from the date of the notice.
      - If you don't provide the missing information/documentation within 6 months of the notice, your application will be closed. You will need to reapply by resubmitting ALL required application materials, including the fee.
      - The processing times listed in 5a above will begin when the application is complete.

PATIENT APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: Complete pages 1 and 3 of this form.
Complete page 2 to designate a caregiver and/or to provide voluntary demographic information.

PATIENT INFORMATION

☐ Initial Application
☐ Renewal Application

Name	First	Last		Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ____________	
Phone Number		**E-Mail Address (optional)**		
Mailing Address	Street/P.O. Box			
	City	State		Zip Code
Physical Address	(If different than mailing address) (If experiencing homelessness, this is not required)			

MEDICAL PROVIDER INFORMATION

Provide information about the medical provider who completed the Written Certification.

Name	First	Last	
Business Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			

MEDICAL INFORMATION RELEASE

I, hereby, authorize the release of relevant medical information by the provider listed above to the NH Department of Health and Human Services if further information about my qualifying medical condition or Written Certification is required by the Department.

______________________________ ______________
Signature of Applicant **Date**

ALTERNATIVE TREATMENT CENTER

Check the box of the Alternative Treatment Center (ATC) you have selected. Select only one box.

☐ Dover – Temescal Wellness
☐ Merrimack / Chichester – Prime Alternative Treatment Centers of NH
☐ Lebanon / Keene – Temescal Wellness
☐ Plymouth / Conway – Sanctuary ATC

DESIGNATED CAREGIVER INFORMATION – OPTIONAL

Read the Designated Caregiver information at the end of this application packet. Your caregiver will need to submit a separate application. Provide the following information about your Designated Caregiver.

Name	First	Last	Middle
Mailing Address	Street/P.O. Box		
	City	State	Zip Code
Date of Birth	MM/DD/YYYY		

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.
The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

PATIENT INFORMATION

Race/Ethnicity
Are you Hispanic, Latino/a, or Spanish origin?
- ☐ No
- ☐ Yes, specify (one or more categories may be selected):
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Another Hispanic, Latino/a, or Spanish origin
  - ☐ Cuban

What is your race? (One or more categories may be selected)
- ☐ White
- ☐ Korean
- ☐ Black or African American
- ☐ Vietnamese
- ☐ American Indian or Alaska Native
- ☐ Other Asian
- ☐ Asian Indian
- ☐ Native Hawaiian
- ☐ Chinese
- ☐ Guamanian or Chamorro
- ☐ Filipino
- ☐ Samoan
- ☐ Japanese
- ☐ Other Pacific Islander

Veteran Status
Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?
☐ No ☐ Yes

Employment
Are you currently: (Check all that apply)
- ☐ Employed full time (35 or more hours per week)
- ☐ Employed part time (up to 35 hours per week)
- ☐ Unemployed and currently looking for work
- ☐ Unemployed and not currently looking for work
- ☐ Student
- ☐ Retired
- ☐ Homemaker
- ☐ Self-employed
- ☐ Unable to work

What is your annual household income?
- ☐ Less than $25,000
- ☐ $75,000 to $99,999
- ☐ $25,000 to $49,999
- ☐ $100,000 or more
- ☐ $50,000 to $74,999

Public Assistance
In the past 12 months, have you been enrolled in a public assistance program?
- ☐ No
- ☐ Yes, specify: (Check all that apply)
  - ☐ Medicaid
  - ☐ Supplemental Security Income (SSI)
  - ☐ Social Security Disability Insurance (SSDI)
  - ☐ Other, specify: ___________

Education
What is the highest level of education completed?
- ☐ Some high school
- ☐ Community college/2-yr degree
- ☐ High school diploma / GED
- ☐ University/4-year college
- ☐ Technical school
- ☐ Graduate program or more

Are you currently enrolled in school?
- ☐ No
- ☐ Yes, specify:
  - ☐ High school
  - ☐ University / 4-year college
  - ☐ Technical school
  - ☐ Graduate program
  - ☐ Community college/2-yr degree

Health Insurance
What is the primary source of your health care coverage?
- ☐ Employer-based plan (including through another person's employer)
- ☐ A plan that you or a family member buys on your own
- ☐ Medicare
- ☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
- ☐ TRICARE, VA, or Military
- ☐ Other source
- ☐ None (no coverage)

Marital Status
What is your marital status?
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Never married
- ☐ Widowed
- ☐ Member of an unmarried partnership

Language Proficiency
How well do you speak English?
☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?
- ☐ No
- ☐ Yes, Spanish
- ☐ Yes, not Spanish. Specify: __________

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that my Registry ID Card is valid for one year, unless a shorter time period is indicated by my provider. I must renew my card every year by submitting another application, certification, and fee.
I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.
I understand that I may not possess, between myself and my Designated Caregiver, more than two ounces of usable cannabis.
I understand that I may only use therapeutic cannabis for the purpose of treating or alleviating my qualifying medical condition.
I understand that I may not be under the influence of therapeutic cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in my place of employment, without the written permission of my employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.
I understand that I may not smoke or vaporize therapeutic cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field.
I understand that I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.
I understand that I may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property.
I have instructed a family member, caretaker, executor, and my Designated Caregiver that, in the event of my death, the Department shall be notified within 5 days that I have died, and that within 5 days of learning of my death, the family member, caretaker, executor, or my Designated Caregiver shall either request that the local law enforcement agency remove any remaining cannabis or dispose of the cannabis in a manner that is specified in RSA 126-X:2, XIV.
I understand that if I am found to be in possession of therapeutic cannabis outside of my home and I am not in possession of my Registry ID Card, I will be subject to a fine of up to $100.
I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to RSA 126-X.
I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within New Hampshire.
I understand that I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke my Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder.
I understand that by using therapeutic cannabis I may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Acknowledgements listed above.

I, hereby, certify that I am a resident of New Hampshire and the facts as stated in this Application are accurate to the best of my knowledge and belief. I understand that any false statements made on this Application are punishable as unsworn falsification under RSA 641:3.

I, hereby, pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, acknowledge that diversion of cannabis shall result in revocation of my Registry ID Card, and acknowledge that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis.

______________________________________ ______________________

Signature of Applicant **Date**

THERAPEUTIC CANNABIS PROGRAM – GENERAL PROGRAM INFORMATION

Minimum Requirements to Become a Qualifying Patient

- You must be a resident of New Hampshire.
- You must be diagnosed by a medical provider as having a qualifying medical condition.
- You must apply for and be issued a valid Registry ID Card by the Therapeutic Cannabis Program (TCP).

Qualifying Medical Conditions

Your medical provider must certify that you have a qualifying medical condition established in law, as follows:

- Moderate to severe chronic pain; OR
- Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects; OR
- Moderate or severe post-traumatic stress disorder; OR
- Any combination of a qualifying diagnosis from (1) <u>AND</u> a qualifying symptom or side effect from (2):
  1. Cancer; glaucoma; positive status for human immunodeficiency virus; acquired immune deficiency syndrome; hepatitis C; amyotrophic lateral sclerosis; muscular dystrophy; Crohn's disease; multiple sclerosis; chronic pancreatitis; spinal cord injury or disease; traumatic brain injury; epilepsy; lupus; Parkinson's disease; Alzheimer's disease; ulcerative colitis; Ehlers-Danlos syndrome; or one or more injuries or conditions that has resulted in one or more qualifying symptoms under (2); AND
  2. Elevated intraocular pressure; cachexia; chemotherapy-induced anorexia; wasting syndrome; agitation of Alzheimer's disease; severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects; constant or severe nausea; moderate to severe vomiting; seizures; or severe, persistent muscle spasms.

Medical Providers

Talk with any of your current medical providers about your interest in the Therapeutic Cannabis Program. Ask if they will certify you for the Program by issuing you a "Written Certification" (available on the Program's website). Any physician, physician assistant, or advanced practice registered nurse (APRN) who is licensed in NH is *permitted* to certify you for the Program. In addition, physicians and APRNs (but not physician assistants) licensed in Maine, Massachusetts, or Vermont are *permitted* to certify you. Out-of-state providers must be primarily responsible for your care related to your qualifying medical condition. <u>State law does not *require* any medical provider to issue a Written Certification to their patient.</u>

There is not a public list of medical providers who participate in the Program. The Program cannot refer you to a provider. You must work with your current providers or develop a relationship with a new provider to become certified.

Your certifying medical provider may:

- Issue a Written Certification for less than one year.
- Send instructions to your ATC, such as the type of cannabis or the means by which the cannabis should be administered, and the ATC is required to follow such instructions.
- Rescind your certification at any time and for any reason if in the provider's opinion you should no longer be certified for the therapeutic use of cannabis.

Designated Caregivers

If you need assistance with your therapeutic use of cannabis, including help with obtaining cannabis from your selected Alternative Treatment Center (ATC), you may designate someone to be your caregiver. You may do this on your initial application or any time after you've been approved. You may designate only one caregiver at a time. <u>**Your caregiver must submit a separate "Caregiver Application,"**</u> and be issued a Registry ID Card before your caregiver can assist you with your therapeutic use of cannabis. The caregiver's Registry ID Card will allow that person to legally possess cannabis on your behalf and to legally purchase cannabis from the Alternative Treatment Center you select.

To be approved as a Designated Caregiver an individual must be at least 21 years old and must never have been convicted of a felony. Your caregiver must undergo a state and federal criminal background check, which includes being fingerprinted, and which requires an additional fee paid to the NH Department of Safety, Division of State Police.

You may use the "Caregiver Designation/Removal" form, available on the Program's website, to designate a caregiver after you've submitted your application or if you want to change your current Designated Caregiver.

GENERAL PROGRAM INFORMATION (Continued)

Alternative Treatment Centers

On your application you are required to select an Alternative Treatment Center (ATC) for the dispensing of therapeutic cannabis. You may select any of the ATCs, but you may select only one at any given time. You can purchase cannabis only from the ATC you have selected. You may change your ATC at any time by completing a "Change of Information/ Lost Card" form and submitting it to the Program. The ATCs in New Hampshire are as follows:

- **Prime Alternative Treatment Centers of NH**, with dispensaries located in **Merrimack** and **Chichester**.
  380 Daniel Webster Highway, Units A and C, Merrimack, NH 03054. Phone: (603) 262-5035
  349 Dover Road (Route 4), Chichester, NH 03258. Phone: (603) 212-1500
  Website: www.primeatc.com. Email: info@primeatc.com.
  Note: The **Merrimack** and **Chichester** dispensaries are considered to be the same ATC. Selecting Prime ATC allows you to go to both locations.
- **Sanctuary ATC**, with dispensaries located in **Plymouth** and **Conway**.
  568 Tenney Mountain Highway, Plymouth, NH 03264
  234 White Mountain Highway (Route16), Conway, NH 03818
  Website: www.sanctuaryatc.org. Email: info@sanctuaryatc.org. Phone: (603) 346-4619
  Note: The Plymouth and Conway dispensaries are considered to be the same ATC. Selecting Sanctuary ATC allows you to go to both locations.
- **Temescal Wellness**, with dispensaries located in **Dover**, and **Lebanon & Keene**.
  26 Crosby Road, Units 11-12, Dover, NH 03820
  367 Route 120, Unit E-2, Lebanon, NH 03766
  69 Island Street, Suite 1, Keene, NH 03431
  Website: www.temescalwellness.com. Email: info@temescalwellness.com. Phone: (603) 285-9383
  Note: The **Lebanon** and **Keene** dispensaries are considered to be the same ATC. Selecting this ATC allows you to go to both locations. The **Dover** dispensary is considered a separate ATC. Selecting the Dover location does not allow you to go to the other Temescal locations.

Confidentiality

The Program will maintain the confidentiality of all personal information about applicants, Qualifying Patients, Designated Caregivers, and certifying medical providers submitted to the Program and contained in the confidential Registry database. Local and state law enforcement officers, however, are allowed to receive limited information from the Registry if a person has been arrested or detained, or when there is probable cause to believe either cannabis is possessed at a specific address or by a specific individual.

Requirements for Minor Patients (under 18 years of age)

Use the "Minor Patient Application" located on the Program's website.

Requirements for Adult Patients Who Have a Legal Guardian or Co-Guardians

- If the legal guardian(s) will be the patient's Designated Caregiver, please use the "Guardianship Patient Application" located on the Program's website.
- If the legal guardian is signing *this* application on behalf of the patient but will *not* be the patient's Designated Caregiver, proof of guardianship must be submitted with this application. Submit a copy of the entire order that shows the powers granted to the guardian, which must include powers related to healthcare decisions.

Renewals

- A Registry ID Card is effective for one year (exceptions are described above under "Medical Providers").
- There is no difference between the initial and the renewal application process, except that proof of NH residency is not required if there has not been a change of address.
- Please use the same Application and Written Certification forms for renewals.
- Submit your renewal application materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.

Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

29 HAZEN DRIVE, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
email: TCP@dhhs.nh.gov

CAREGIVER APPLICATION

For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

Information about the Therapeutic Cannabis Program, including the law (RSA 126-X), the rules (He-C 400), and all required forms, is available on the Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

1. Read the "General Program Information" at the end of this application packet.
2. Complete ALL information on pages 1 and 3. Complete page 2 if you want to provide voluntary demographic information.
3. Mail or hand-deliver the following:

Required Documents:	To This Address:
☐ A completed Caregiver Application ☐ "Attestation of No Felony Conviction" form **(Renewal Only)** **(See 4 below for Initial application)**	NH Department of Health and Human Services Therapeutic Cannabis Program 29 Hazen Drive Concord, NH 03301

4. **Criminal Background Check Required**.
   - For an initial application, you will need to have the results of a criminal history records check released to the Program before your application will be considered complete. Please see the "General Program Information" and the "Criminal History Record Information Authorization" form at the end of this application packet for specific instructions regarding the state and federal background check, which requires you to be fingerprinted. You must have no felony convictions on your record.
   - For a renewal application, a new criminal history records check is *not* required. Instead, you must submit a signed "Attestation of No Felony Conviction" form, at the end of this application packet. If there is a lapse in your registration of more than one year, the results of a new criminal history records check are required.
5. In order for your application to be complete, your patient must designate you as their caregiver on their "Patient Application" or on the "Caregiver Designation/Removal" form, and your patient must be approved and be issued a Registry ID Card.
6. Application processing:
   a. Application processing takes up to 3 weeks.
      - The Program will approve or deny a complete application within 15 days of receipt.
      - The Program will issue a Registry ID Card within 5 days of approval.
   b. Incomplete applications:
      - You will be notified in writing within 10 days if an application is incomplete.
      - You will be asked to submit the missing information/documentation within 30 days from the date of the notice.
      - If you don't provide the missing information/documentation within 6 months of the notice, your application will be closed. You will need to reapply by resubmitting ALL required application materials.
      - The processing times listed in 6a above will begin when the application is complete.

CAREGIVER APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: Complete pages 1 and 3 of this form.
Complete page 2 to provide voluntary demographic information.

CAREGIVER INFORMATION

☐ Initial Application ☐ Renewal Application	If an initial application, have you sent the Criminal Record Authorization Form and the required fee to the NH Department of Safety? ☐ Yes ☐ No		
Name	First	Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ____________________
Phone Number		**E-Mail Address (optional)**	
Mailing Address	Street/P.O. Box		
	City	State	Zip Code
Physical Address	(If different than mailing address)		

PATIENT INFORMATION

Provide information about the Patient for whom you will be serving as a Caregiver

Name	First	Last	Middle
Mailing Address	Street/P.O. Box		
	City	State	Zip Code
Physical Address	(If different than mailing address) (If patient is experiencing homelessness, this is not required)		
Date of Birth	MM/DD/YYYY		

You may be the Caregiver for up to five Patients.
Additional patients may be added by completing additional copies of this page.

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

CAREGIVER INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- ☐ No
- ☐ Yes, specify (one or more categories may be selected):
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Another Hispanic, Latino/a, or Spanish origin
  - ☐ Cuban

What is your race? (One or more categories may be selected)

- ☐ White
- ☐ Korean
- ☐ Black or African American
- ☐ Vietnamese
- ☐ American Indian or Alaska Native
- ☐ Other Asian
- ☐ Asian Indian
- ☐ Native Hawaiian
- ☐ Chinese
- ☐ Guamanian or Chamorro
- ☐ Filipino
- ☐ Samoan
- ☐ Japanese
- ☐ Other Pacific Islander

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

☐ No ☐ Yes

Employment

Are you currently: (Check all that apply)

- ☐ Employed full time (35 or more hours per week)
- ☐ Employed part time (up to 35 hours per week)
- ☐ Unemployed and currently looking for work
- ☐ Unemployed and not currently looking for work
- ☐ Student ☐ Retired ☐ Homemaker
- ☐ Self-employed ☐ Unable to work

What is your annual household income?

- ☐ Less than $25,000
- ☐ $75,000 to $99,999
- ☐ $25,000 to $49,999
- ☐ $100,000 or more
- ☐ $50,000 to $74,999

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

- ☐ No
- ☐ Yes, specify: (Check all that apply)
  - ☐ Medicaid
  - ☐ Supplemental Security Income (SSI)
  - ☐ Social Security Disability Insurance (SSDI)
  - ☐ Other, specify: ___________

Education

What is the highest level of education completed?

- ☐ Some high school
- ☐ Community college/2-yr degree
- ☐ High school diploma / GED
- ☐ University/4-year college
- ☐ Technical school
- ☐ Graduate program or more

Are you currently enrolled in school?

- ☐ No
- ☐ Yes, specify:
  - ☐ High school
  - ☐ University / 4-year college
  - ☐ Technical school
  - ☐ Graduate program
  - ☐ Community college/2-yr degree

Health Insurance

What is the primary source of your health care coverage?

- ☐ Employer-based plan (including through another person's employer)
- ☐ A plan that you or a family member buys on your own
- ☐ Medicare
- ☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
- ☐ TRICARE, VA, or Military
- ☐ Other source
- ☐ None (no coverage)

Marital Status

What is your marital status?

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Never married
- ☐ Widowed
- ☐ Member of an unmarried partnership

Language Proficiency

How well do you speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?

- ☐ No
- ☐ Yes, Spanish
- ☐ Yes, not Spanish. Specify:_________

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that my Registry ID Card is valid for one year, unless a shorter duration is indicated. I must renew my card every year by submitting another application.
I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.
I understand that I may not possess, between myself and my Qualifying Patient(s), more than two ounces of usable cannabis per Qualifying Patient.
I understand that as a Designated Caregiver I am not permitted to use therapeutic cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so.
I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X.
I understand that I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.
I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Department of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV.
I understand that if I am found to be in possession of therapeutic cannabis outside of my home and I am not in possession of my Registry ID Card, I may be subject to a fine of up to $100.
I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.
I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within New Hampshire.
I understand that I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke my Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder.
I understand that I, by possessing therapeutic cannabis, and my Qualifying Patient, by using therapeutic cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Acknowledgements listed above.

I, hereby, agree to act as the Designated Caregiver for the Qualifying Patient(s) named in this Application, and I certify that the facts as stated in this Application are accurate to the best of my knowledge and belief. I understand that any false statements made on this Application are punishable as unsworn falsification under RSA 641:3.

I, hereby, pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, acknowledge that diversion of cannabis shall result in revocation of my Registry ID Card, and acknowledge that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis.

Signature of Applicant **Date**

THERAPEUTIC CANNABIS PROGRAM – GENERAL PROGRAM INFORMATION

Minimum Requirements to Become a Designated Caregiver

- You must be at least 21 years old.
- You must never have been convicted of a felony.
- You must be designated as caregiver on your patient's application, and that patient must be approved for the Program.

Criminal History Records Check

Your initial application will not be considered complete until the NH Department of Safety, Division of State Police, has released the results of state and federal criminal history records check to the Program. This background check requires you to be fingerprinted, and to pay an additional fee to the NH Division of State Police. Conducting the criminal records check can sometimes be a lengthy process. It is advisable to begin the criminal history records check process prior to submitting your application to the Program.

- Follow the instructions on the second page of the "Criminal History Record Information Authorization for Therapeutic Cannabis" form, which is attached to the end of this application packet and available on the Program's website.
- The Division of State Police will conduct a criminal history records check through its records and through FBI records
- They will release to the Program the results of the criminal records check, which shall be limited to whether or not you have been convicted of a felony.
- In the event that, after two attempts, your electronic fingerprints are invalid due to insufficient pattern, the Program may, in lieu of a criminal history records check, accept police clearances from every city, town, or county where you have lived during the past five years. You will need to work with the Division of State Police to obtain these clearances.

Number of Qualifying Patients Allowed

You may be the Designated Caregiver for up to five Qualifying Patients. An exception to this limit is if both you and any Qualifying Patients over and above five live more than a 50-mile drive from the nearest Alternative Center (ATC), in which case you may be the Designated Caregiver for up to nine Qualifying Patients. For example, if you want to have six Qualifying Patients, both you and at least one of the six Qualifying Patients must live more than a 50-mile drive from the nearest ATC.

Designated Caregiver List of Qualifying Patients

The Program will provide you with a current list of Qualifying Patients for whom you serve as Designated Caregiver. The Program strongly advises that you carry this document with you when transporting or possessing therapeutic cannabis. The information contained in the document is confidential; however, it may be shared with law enforcement officers.

Compensation

A Designated Caregiver may receive compensation from your Qualifying Patient for actual costs, such as gas, tolls, and the costs of any cannabis products purchased, but not for any time or labor associated with assisting your Qualifying Patient(s) with their therapeutic use of cannabis.

Confidentiality

The Program will maintain the confidentiality of all personal information about applicants, Qualifying Patients, Designated Caregivers, and certifying medical providers submitted to the Program and contained in the confidential Registry database. Local and state law enforcement officers, however, are allowed to receive limited information from the Registry if a person has been arrested or detained, or when there is probable cause to believe either cannabis is possessed at a specific address or by a specific individual.

Renewals

- A Registry ID Card is effective for one year.
- Please use this same application form for renewals.
- For a renewal, a new criminal records check is not required. Instead, you must submit a signed "Attestation of No Felony Conviction" form, which is available on the Program's website.
- Submit your renewal application materials at least 30 days prior to your card's expiration to prevent a lapse in your registration.
- If there is a lapse in your registration of more than one year, you will be required to have the results of a new criminal history records check released to the Program.

Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

29 HAZEN DRIVE, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
email: TCP@dhhs.nh.gov

MINOR PATIENT APPLICATION

For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

Information about the Therapeutic Cannabis Program, including the law (RSA 126-X), the rules (He-C 400), and all required forms, is available on the Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

MINOR PATIENT APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: Complete all pages of this form.

☐ Initial Application ☐ Renewal Application	If an initial application, have you (the Caregiver Applicant) sent the Criminal Record Authorization Form and the required fee to the NH Department of Safety? ☐ Yes ☐ No

MINOR PATIENT INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ______________________	
Mailing Address	Street/P.O. Box			
	City		State	Zip Code
Physical Address	(If different than mailing address) (If experiencing homelessness, this is not required)			

DESIGNATED CAREGIVER INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ______________________	
Phone Number		**E-Mail Address (optional)**		
Mailing Address	Street/P.O. Box			
(if different than the patient)	City		State	Zip Code
Physical Address	(If different than the patient)			

SECOND DESIGNATED CAREGIVER INFORMATION – OPTIONAL

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ______________________	
Phone Number		**E-Mail Address (optional)**		
Mailing Address	Street/P.O. Box			
(if different than the patient)	City		State	Zip Code
Physical Address	(If different than the patient)			

MEDICAL PROVIDER INFORMATION

Provide information about the two medical providers who completed the Written Certifications.
One of the providers must be a pediatrician.

Name	First	Last	
Business Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			

SECOND MEDICAL PROVIDER INFORMATION

Name	First	Last	
Business Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			

MEDICAL INFORMATION RELEASE

I, hereby, authorize the release of relevant medical information by the providers listed above to the NH Department of Health and Human Services if further information about the qualifying medical condition or Written Certification is required by the Department.

____ ______________________________

Signature of Minor Patient's custodial parent or legal guardian **Date**

ALTERNATIVE TREATMENT CENTER

Check the box of the Alternative Treatment Center (ATC) you have selected. Select only one box.

- ☐ Dover – Temescal Wellness
- ☐ Merrimack / Chichester – Prime Alternative Treatment Centers of NH
- ☐ Lebanon / Keene – Temescal Wellness
- ☐ Plymouth / Conway – Sanctuary ATC

DESIGNATED CAREGIVER REQUIREMENTS FOR A MINOR PATIENT

The Designated Caregiver(s) must attest to the following, by signing on the following page.

I am the applicant's custodial parent or legal guardian responsible for the health care decisions of the applicant.

The applicant's certifying providers have explained to me the potential risks and benefits of the therapeutic use of cannabis.

I consent to allow the applicant's therapeutic use of cannabis.

I consent to serve as the applicant's Designated Caregiver and to control the acquisition of cannabis and the frequency of the therapeutic use of cannabis by the applicant.

I understand that if I am not approved to be a Designated Caregiver, then the applicant's application to be a Qualifying Patient will not be approved.

(If applicable) I share legal custody of the applicant, and I have notified the other parent or guardian with legal custody of the applicant in advance of submitting this application by having provided to the other parent or guardian a copy of the completed Application form and the completed Written Certification forms.

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that Registry ID Cards are valid for one year, unless a shorter duration is indicated. Cards must be renewed every year by submitting another application and fee.
I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.
I understand that I may not possess, between myself and my Qualifying Patient, more than two ounces of usable cannabis per Qualifying Patient.
I understand that as a Designated Caregiver I am not permitted to use therapeutic cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so.
I understand that my Qualifying Patient may only use therapeutic cannabis for the purpose of treating or alleviating their qualifying medical condition.
I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X.
I understand that my Qualifying Patient may not be under the influence of therapeutic cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in their place of employment, without the written permission of the employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.
I understand that my Qualifying Patient may not smoke or vaporize therapeutic cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field.
I understand that my Qualifying Patient and I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.
I understand that my Qualifying Patient may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property.
I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Department of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV.
I understand that if my Qualifying Patient or I am found to be in possession of therapeutic cannabis outside of our home and we are not in possession of a Registry ID Card, we may be subject to a fine of up to $100.
I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.
I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within NH.
I understand that my Qualifying Patient and I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke a Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder.
I understand that I, by possessing therapeutic cannabis, and my Qualifying Patient, by using therapeutic cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Designated Caregiver Requirements for a Minor Patient listed on Page 2 and the Acknowledgements listed above.

I, hereby, certify that the minor patient is a resident of New Hampshire and the facts as stated in this Application are accurate to the best of my knowledge and belief. I understand that any false statements made on this Application are punishable as unsworn falsification under RSA 641:3.

I, hereby, pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, acknowledge that diversion of cannabis shall result in revocation of my Registry ID Card, and acknowledge that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis.

______________________________ ______________

Signature of Patient's custodial parent or legal guardian **Date**

______________________________ ______________

Signature of Patient's second custodial parent or legal guardian (if applicable) **Date**

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

PATIENT INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- ☐ No
- ☐ Yes, specify (one or more categories may be selected):
  - ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a, or Spanish origin

What is your race? (One or more categories may be selected)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

CAREGIVER INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- ☐ No
- ☐ Yes, specify (one or more categories may be selected):
  - ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican
  - ☐ Another Hispanic, Latino/a, or Spanish origin ☐ Cuban

What is your race? (One or more categories may be selected)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

☐ No ☐ Yes

Employment

Are you currently: (Check all that apply)

- ☐ Employed full time (35 or more hours per week)
- ☐ Employed part time (up to 35 hours per week)
- ☐ Unemployed and currently looking for work
- ☐ Unemployed and not currently looking for work
- ☐ Student ☐ Retired ☐ Homemaker
- ☐ Self-employed ☐ Unable to work

What is your annual household income?

- ☐ Less than $25,000
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 or more

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

- ☐ No
- ☐ Yes, specify: (Check all that apply)
  - ☐ Medicaid
  - ☐ Supplemental Security Income (SSI)
  - ☐ Social Security Disability Insurance (SSDI)
  - ☐ Other, specify: __________

Education

What is the highest level of education completed?

- ☐ Some high school
- ☐ High school diploma / GED
- ☐ Technical school
- ☐ Community college/2-yr degree
- ☐ University/4-year college
- ☐ Graduate program or more

Are you currently enrolled in school?

- ☐ No
- ☐ Yes, specify:
  - ☐ High school
  - ☐ Technical school
  - ☐ Community college/2-yr degree
  - ☐ University / 4-year college
  - ☐ Graduate program

Health Insurance

What is the primary source of your health care coverage?

- ☐ Employer-based plan (including through another person's employer)
- ☐ A plan that you or a family member buys on your own
- ☐ Medicare
- ☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
- ☐ TRICARE, VA, or Military
- ☐ Other source
- ☐ None (no coverage)

Marital Status

What is your marital status?

- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Never married
- ☐ Member of an unmarried partnership

Language Proficiency

How well do you speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?

- ☐ No
- ☐ Yes, Spanish
- ☐ Yes, not Spanish. Specify: _________

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

SECOND CAREGIVER INFORMATION

Race/Ethnicity
Are you Hispanic, Latino/a, or Spanish origin?
☐ No
☐ Yes, specify (one or more categories may be selected):
☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican
☐ Another Hispanic, Latino/a, or Spanish origin ☐ Cuban

What is your race? (One or more categories may be selected)
☐ White ☐ Korean
☐ Black or African American ☐ Vietnamese
☐ American Indian or Alaska Native ☐ Other Asian
☐ Asian Indian ☐ Native Hawaiian
☐ Chinese ☐ Guamanian or Chamorro
☐ Filipino ☐ Samoan
☐ Japanese ☐ Other Pacific Islander

Veteran Status
Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?
☐ No ☐ Yes

Employment
Are you currently: (Check all that apply)
☐ Employed full time (35 or more hours per week)
☐ Employed part time (up to 35 hours per week)
☐ Unemployed and currently looking for work
☐ Unemployed and not currently looking for work
☐ Student ☐ Retired ☐ Homemaker
☐ Self-employed ☐ Unable to work

What is your annual household income?
☐ Less than $25,000 ☐ $75,000 to $99,999
☐ $25,000 to $49,999 ☐ $100,000 or more
☐ $50,000 to $74,999

Public Assistance
In the past 12 months, have you been enrolled in a public assistance program?
☐ No
☐ Yes, specify: (Check all that apply)
☐ Medicaid
☐ Supplemental Security Income (SSI)
☐ Social Security Disability Insurance (SSDI)
☐ Other, specify: __________

Education
What is the highest level of education completed?
☐ Some high school ☐ Community college/2-yr degree
☐ High school diploma / GED ☐ University/4-year college
☐ Technical school ☐ Graduate program or more

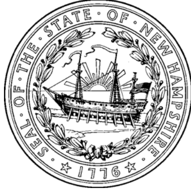
Are you currently enrolled in school?
☐ No
☐ Yes, specify:
☐ High school ☐ University / 4-year college
☐ Technical school ☐ Graduate program
☐ Community college/2-yr degree

Health Insurance
What is the primary source of your health care coverage?
☐ Employer-based plan (including through another person's employer)
☐ A plan that you or a family member buys on your own
☐ Medicare
☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
☐ TRICARE, VA, or Military
☐ Other source
☐ None (no coverage)

Marital Status
What is your marital status?
☐ Married ☐ Separated
☐ Divorced ☐ Never married
☐ Widowed ☐ Member of an unmarried partnership

Language Proficiency
How well do you speak English?
☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?
☐ No
☐ Yes, Spanish
☐ Yes, not Spanish. Specify:_________



Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

29 HAZEN DRIVE, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
email: TCP@dhhs.nh.gov

GUARDIANSHIP PATIENT APPLICATION

For the Therapeutic Use of Cannabis

APPLICATION INSTRUCTIONS

Information about the Therapeutic Cannabis Program, including the law (RSA 126-X), the rules (He-C 400), and all required forms, is available on the Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

GUARDIANSHIP PATIENT APPLICATION FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: Complete all pages of this form.

☐ Initial Application ☐ Renewal Application	If an initial application, have you (the Caregiver Applicant) sent the Criminal Record Authorization Form and the required fee to the NH Department of Safety? ☐ Yes ☐ No

PATIENT INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ______	
Phone Number (optional)		**E-Mail Address** (optional)		
Mailing Address	Street/P.O. Box			
	City		State	Zip Code
Physical Address	(If different than mailing address) (If experiencing homelessness, this is not required)			

DESIGNATED CAREGIVER INFORMATION

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ______	
Phone Number		**E-Mail Address** (optional)		
Mailing Address (if different than the patient)	Street/P.O. Box			
	City		State	Zip Code
Physical Address	(If different than the patient)			

SECOND DESIGNATED CAREGIVER INFORMATION – OPTIONAL

Name	First		Last	Middle
Date of Birth	MM/DD/YYYY	**Gender**	☐ Female ☐ Male ☐ Non-binary/Other gender ☐ Choose not to disclose ☐ Choose to self-describe: ______	
Phone Number		**E-Mail Address** (optional)		
Mailing Address (if different than the patient)	Street/P.O. Box			
	City		State	Zip Code
Physical Address	(If different than the patient)			

MEDICAL PROVIDER INFORMATION

Provide information about the medical provider who completed the Written Certification.

Name	First	Last	
Business Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			

MEDICAL INFORMATION RELEASE

I, hereby, authorize the release of relevant medical information by the providers listed above to the NH Department of Health and Human Services if further information about the qualifying medical condition or Written Certification is required by the Department.

Signature of Applicant's custodial parent or legal guardian **Date**

ALTERNATIVE TREATMENT CENTER

Check the box of the Alternative Treatment Center (ATC) you have selected. Select only one box.

- ☐ Dover – Temescal Wellness
- ☐ Merrimack / Chichester – Prime Alternative Treatment Centers of NH
- ☐ Lebanon / Keene – Temescal Wellness
- ☐ Plymouth / Conway – Sanctuary ATC

THERAPEUTIC CANNABIS PROGRAM ACKNOWLEDGEMENTS

I understand that Registry ID Cards are valid for one year, unless a shorter duration is indicated. Cards must be renewed every year by submitting another application and fee.
I understand that if I am notified of a denial I have 30 days to appeal the decision from the date of the notice, and that if a hearing request is not made within that timeframe then I will have waived my right to a hearing and the action of the Department shall become final.
I understand that I may not possess, between myself and my Qualifying Patient, more than two ounces of usable cannabis per Qualifying Patient.
I understand that as a Designated Caregiver I am not permitted to use therapeutic cannabis, unless I am also a Qualifying Patient, and may be subject to criminal penalties if I do so.
I understand that my Qualifying Patient may only use therapeutic cannabis for the purpose of treating or alleviating their qualifying medical condition.
I understand that as a Designated Caregiver I am not permitted to possess any cannabis for purposes other than its therapeutic use as permitted by RSA 126-X.
I understand that my Qualifying Patient may not be under the influence of therapeutic cannabis: (1) while operating a motor vehicle, commercial vehicle, boat, vessel, or any other vehicle propelled or drawn by power other than muscular power; (2) in their place of employment, without the written permission of the employer; or (3) while operating heavy machinery or handling a dangerous instrumentality.
I understand that my Qualifying Patient may not smoke or vaporize therapeutic cannabis in any public place, including a public bus or other public vehicle, or any public park, public beach, or public field.
I understand that my Qualifying Patient and I may not be in possession of therapeutic cannabis in any of the following locations: (1) the building and grounds of any preschool, elementary, or secondary school, which are located in an area designated as a drug free zone; (2) a place of employment, without the written permission of the employer; (3) any correctional facility; (4) any public recreation center or youth center; or (5) any law enforcement facility.
I understand that my Qualifying Patient may use cannabis on privately-owned real property only with written permission of the property owner or, in the case of leased property, with the permission of the tenant in possession of the property.
I understand that in the event of my Qualifying Patient's death, I will, within 5 days of the death: (1) notify the Department of the death; and (2) either request that the local law enforcement agency remove any remaining cannabis or dispose of the remaining cannabis in a manner that is specified in RSA 126-X:2, XIV.
I understand that if my Qualifying Patient or I am found to be in possession of therapeutic cannabis outside of our home and we are not in possession of a Registry ID Card, we may be subject to a fine of up to $100.
I understand that any person(s) who makes a fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation and may be fined $500, which shall be in addition to any other penalties that may apply for making a false statement to a law enforcement officer or for the use of cannabis other than use undertaken pursuant to this RSA 126-X.
I understand that the protections conferred by RSA 126-X for the therapeutic use of cannabis are applicable only within NH.
I understand that my Qualifying Patient and I must be in compliance with RSA 126-X and with the administrative rules adopted thereunder, and that the Department may revoke a Registry ID Card for any violation of any provision of RSA 126-X or the administrative rules adopted thereunder.
I understand that I, by possessing therapeutic cannabis, and my Qualifying Patient, by using therapeutic cannabis, may be denied rights and privileges by federal agencies including, but not limited to, those related to employment such as driving a commercial vehicle, those related to owning, possessing, or purchasing a firearm and ammunition, those related to federal housing, those related to immigration and naturalization, or the inability to pass a security clearance.

CERTIFICATION AND NON-DIVERSION PLEDGE

I, hereby, attest to the Acknowledgements listed above.

I, hereby, certify that the patient is a resident of New Hampshire and the facts as stated in this Application are accurate to the best of my knowledge and belief. I understand that any false statements made on this Application are punishable as unsworn falsification under RSA 641:3.

I, hereby, pledge not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to RSA 126-X, acknowledge that diversion of cannabis shall result in revocation of my Registry ID Card, and acknowledge that the sale of cannabis to anyone who is not a qualifying patient of a designated caregiver is punishable as a class B felony with a sentence of a maximum term of imprisonment of not more than 7 years, and a fine of not more than $300,000, or both, in addition to other penalties for the illegal sale of cannabis.

______________________________ ______________

Signature of Patient's custodial parent or legal guardian **Date**

______________________________ ______________

Signature of Patient's custodial parent or legal guardian (if applicable) **Date**

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

PATIENT INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

☐ No
☐ Yes, specify (one or more categories may be selected):
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Cuban

What is your race? (One or more categories may be selected)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

☐ No ☐ Yes

Employment

Are you currently: (Check all that apply)

☐ Employed full time (35 or more hours per week)
☐ Employed part time (up to 35 hours per week)
☐ Unemployed and currently looking for work
☐ Unemployed and not currently looking for work
☐ Student ☐ Retired ☐ Homemaker
☐ Self-employed ☐ Unable to work

What is your annual household income?

☐ Less than $25,000
☐ $25,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 or more

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

☐ No
☐ Yes, specify: (Check all that apply)
- ☐ Medicaid
- ☐ Supplemental Security Income (SSI)
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Other, specify: __________

Education

What is the highest level of education completed?

☐ Some high school
☐ High school diploma / GED
☐ Technical school
☐ Community college/2-yr degree
☐ University/4-year college
☐ Graduate program or more

Are you currently enrolled in school?

☐ No
☐ Yes, specify:
- ☐ High school
- ☐ Technical school
- ☐ Community college/2-yr degree
- ☐ University / 4-year college
- ☐ Graduate program

Health Insurance

What is the primary source of your health care coverage?

☐ Employer-based plan (including through another person's employer)
☐ A plan that you or a family member buys on your own
☐ Medicare
☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
☐ TRICARE, VA, or Military
☐ Other source
☐ None (no coverage)

Marital Status

What is your marital status?

☐ Married ☐ Separated
☐ Divorced ☐ Never married
☐ Widowed ☐ Member of an unmarried partnership

Language Proficiency

How well do you speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?

☐ No
☐ Yes, Spanish
☐ Yes, not Spanish. Specify: __________

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

CAREGIVER INFORMATION

Race/Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?

- ☐ No
- ☐ Yes, specify (one or more categories may be selected):
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Another Hispanic, Latino/a, or Spanish origin
  - ☐ Cuban

What is your race? (One or more categories may be selected)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

Veteran Status

Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?

☐ No ☐ Yes

Employment

Are you currently: (Check all that apply)

- ☐ Employed full time (35 or more hours per week)
- ☐ Employed part time (up to 35 hours per week)
- ☐ Unemployed and currently looking for work
- ☐ Unemployed and not currently looking for work
- ☐ Student ☐ Retired ☐ Homemaker
- ☐ Self-employed ☐ Unable to work

What is your annual household income?

- ☐ Less than $25,000
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 or more

Public Assistance

In the past 12 months, have you been enrolled in a public assistance program?

- ☐ No
- ☐ Yes, specify: (Check all that apply)
  - ☐ Medicaid
  - ☐ Supplemental Security Income (SSI)
  - ☐ Social Security Disability Insurance (SSDI)
  - ☐ Other, specify: __________

Education

What is the highest level of education completed?

- ☐ Some high school
- ☐ High school diploma / GED
- ☐ Technical school
- ☐ Community college/2-yr degree
- ☐ University/4-year college
- ☐ Graduate program or more

Are you currently enrolled in school?

- ☐ No
- ☐ Yes, specify:
  - ☐ High school
  - ☐ Technical school
  - ☐ Community college/2-yr degree
  - ☐ University / 4-year college
  - ☐ Graduate program

Health Insurance

What is the primary source of your health care coverage?

- ☐ Employer-based plan (including through another person's employer)
- ☐ A plan that you or a family member buys on your own
- ☐ Medicare
- ☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
- ☐ TRICARE, VA, or Military
- ☐ Other source
- ☐ None (no coverage)

Marital Status

What is your marital status?

- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Never married
- ☐ Member of an unmarried partnership

Language Proficiency

How well do you speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?

- ☐ No
- ☐ Yes, Spanish
- ☐ Yes, not Spanish. Specify:_________

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested.

The information on this page will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected information.

SECOND CAREGIVER INFORMATION

Race/Ethnicity
Are you Hispanic, Latino/a, or Spanish origin?
- ☐ No
- ☐ Yes, specify (one or more categories may be selected):
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Another Hispanic, Latino/a, or Spanish origin
  - ☐ Cuban

What is your race? (One or more categories may be selected)
- ☐ White
- ☐ Korean
- ☐ Black or African American
- ☐ Vietnamese
- ☐ American Indian or Alaska Native
- ☐ Other Asian
- ☐ Asian Indian
- ☐ Native Hawaiian
- ☐ Chinese
- ☐ Guamanian or Chamorro
- ☐ Filipino
- ☐ Samoan
- ☐ Japanese
- ☐ Other Pacific Islander

Veteran Status
Have you ever served on active duty in the US Armed Forces, either in the regular military or in a National Guard or military reserve unit?
☐ No ☐ Yes

Employment
Are you currently: (Check all that apply)
- ☐ Employed full time (35 or more hours per week)
- ☐ Employed part time (up to 35 hours per week)
- ☐ Unemployed and currently looking for work
- ☐ Unemployed and not currently looking for work
- ☐ Student ☐ Retired ☐ Homemaker
- ☐ Self-employed ☐ Unable to work

What is your annual household income?
- ☐ Less than $25,000
- ☐ $75,000 to $99,999
- ☐ $25,000 to $49,999
- ☐ $100,000 or more
- ☐ $50,000 to $74,999

Public Assistance
In the past 12 months, have you been enrolled in a public assistance program?
- ☐ No
- ☐ Yes, specify: (Check all that apply)
  - ☐ Medicaid
  - ☐ Supplemental Security Income (SSI)
  - ☐ Social Security Disability Insurance (SSDI)
  - ☐ Other, specify: __________

Education
What is the highest level of education completed?
- ☐ Some high school
- ☐ Community college/2-yr degree
- ☐ High school diploma / GED
- ☐ University/4-year college
- ☐ Technical school
- ☐ Graduate program or more

Are you currently enrolled in school?
- ☐ No
- ☐ Yes, specify:
  - ☐ High school
  - ☐ University / 4-year college
  - ☐ Technical school
  - ☐ Graduate program
  - ☐ Community college/2-yr degree

Health Insurance
What is the primary source of your health care coverage?
- ☐ Employer-based plan (including through another person's employer)
- ☐ A plan that you or a family member buys on your own
- ☐ Medicare
- ☐ Medicaid, including Healthy Families, Well Sense, or AmeriHealth Caritas
- ☐ TRICARE, VA, or Military
- ☐ Other source
- ☐ None (no coverage)

Marital Status
What is your marital status?
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Never married
- ☐ Widowed
- ☐ Member of an unmarried partnership

Language Proficiency
How well do you speak English?
☐ Very well ☐ Well ☐ Not well ☐ Not at all

Do you speak another language other than English at home?
- ☐ No
- ☐ Yes, Spanish
- ☐ Yes, not Spanish. Specify:_________