Virginia Department of Health Professions
Board of Pharmacy

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4456 (Tel)
(804) 527-4472 (Fax)
cbd@dhp.virginia.gov
www.dhp.virginia.gov/pharmacy

Application for Registration as a Patient for Cannabis Oil

Application Fee: $50.00

The required non-refundable fee must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant - Please provide the information requested below. (Print Legibly or Type)

Name: Last	First		Middle/Maiden	
Street Address	City	State	Zip Code	Tel Number
Date of Birth ____ ____ / ____ ____ / ____ ____ ____ ____	Social Security Number or Virginia DMV Control Number			
Email Address				

PLEASE ANSWER THE FOLLOWING QUESTIONS:

		YES	NO
1.	Is this application for a minor or incapacitated adult patient? **A.** If yes, provide your full name as parent/guardian and email address. Parent/Guardian Full Name: _____ Parent/Guardian Email Address: _____ **B.** If yes, the parent/legal guardian must also submit the ***Application for Registration as a Parent/Guardian for Cannabis Oil***.	☐	☐
2.	Does the patient reside in the Commonwealth of Virginia? **Individuals not residing in Virginia are ineligible for registration.**	☐	☐
3.	Has the patient had a prior conviction of a violation of any law pertaining to controlled substances? If yes, please provide a full explanation and attach any associated orders or letters from the enforcing entity. (If additional space is needed, provide as an attachment.) _____ _____ _____ _____ _____	☐	☐
4.	Has this patient had a registration for cannabis oil denied, suspended or revoked by the board in the previous six months?	☐	☐

5.	By entering my initials, I understand that I must submit, as an attachment to this application, proof of the patient's residency, proof of the patient's identity, proof of the patient's age, and a copy of the cannabis oil written certification. (DO NOT SEND THE ORIGINAL DOCUMENTATION) If I am the parent/legal guardian of the patient who is a minor or incapacitated adult, I further understand that I must also submit the *Application for Registration as a Parent/Guardian for Cannabis Oil.*	**INITIALS** _____

Applicant's Certification: (the following must be signed and dated)

I certify by entering my signature below: I am the patient or the parent/legal guardian of the patient who is a minor or incapacitated adult applying for registration and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing registration.

Printed Name of Patient or Parent/Legal Guardian of Patient is who is a Minor or Incapacitated Adult	Date
Signature of Patient or Parent/Legal Guardian of Patient is who is a Minor or Incapacitated Adult	Date