Arkansas Department of Health

Medical Marijuana Registry Caregiver Application

Caregiver Information	☐ New Application	☐ Renewal
First Name	MI	Last Name

Mailing Address			
Street Number and Street Name (or PO Box)			
Unit Number	Unit Type (Apt, Unit, Suite, etc.)		
City		State	Zip Code

Residence Address (if different from mailing address)				
Street Number and Street Name				
Unit Number	Unit Type (Apt, Unit, Suite, etc.)			
City			State	Zip Code
Date of Birth (MM/DD/YYYY)	Sex ☐Male ☐Female	Race	Eye Color	Height ' "
Arkansas DL or ID Number	Expiration Date (MM/DD/YYYY)		Last 4 digits of SSN	Registry ID (for renewals only)

Patient for which you intend to provide care			
First Name	MI	Last Name	Registry ID (for renewals only)
Street Number and Street Name			
Unit Number	Unit Type (Apt, Unit, Suite, etc.)		
City		State	Zip Code

☐ Yes	☐ No	Is the above patient physically disabled?
☐ Yes	☐ No	Is the above patient under 18 years of age?
☐ Yes	☐ No	Are you the parent of the above patient?

☐ Yes	☐ No	Are you a member of the Arkansas National Guard or the United States military?

By signing, I, pledge not to divert marijuana to anyone who is not allowed to possess marijuana under the Arkansas Medical Marijuana Amendment of 2016

Signature	Date
Print Name	