



Arkansas Department of Health
Medical Marijuana Registry Caregiver Application



Caregiver Information					<input type="checkbox"/> New Application		<input type="checkbox"/> Renewal	
First Name			MI	Last Name			Phone	
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 <input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the above patient physically disabled?						
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the above patient under 18 years of age?						
<input type="checkbox"/> Yes <input type="checkbox"/> No		Are you the parent of the above patient?						

<input type="checkbox"/> Yes <input type="checkbox"/> 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								