



**Rhode Island Department of Health
Division of Health Professionals Regulation**

3 Capitol Hill, Room 104
Providence, RI 02908-5097

Instructions and Application For

**Medical Marijuana
Compassion Center Staff**

- Principal Officer
- Board Member
- Agent
- Employee
- Volunteer

Full Name

GENERAL INFORMATION

1. Requirements for licensure are established by the Rules and Regulations Relating to Medical Marijuana Program (R21-28.6-MMP), available through the Department of Health's website at <http://www.health.ri.gov/healthcare/medicalmarijuana/index.php>. Links for Public Laws and Statute are also available.
2. Should you have any questions regarding the license requirements or completion of the application form, contact the Division of Health Professions Regulation at (401) 222-3752.

APPLICATION INSTRUCTIONS

1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed. Please mark "NA" on questions that are Not Applicable. Please use a ball-point type pen when completing these forms.
2. Do not detach any full pages from this booklet.
3. Sign the application and return it with a check or money order payable to the General Treasurer, State of Rhode Island.
4. Do not submit the application without all applicable information, documentation and fee(s).
5. Mail the completed application to:
Rhode Island Department of Health
Division of Health Professions Regulation
Room 104, 3 Capitol Hill
Providence, RI 02908-5097

REQUIRED DOCUMENTATION

- Completed and signed Application for **each** principal officer, board member, agent, employee or volunteer.
- **Each principal officer or board member** must reside in Rhode Island. Proof of Rhode Island residency is required. (Proof must be in the form of a copy of a Rhode Island Government issued photo ID)
- A non-returnable, non-refundable application fee payable to General Treasurer, State of Rhode Island in the amount of one-hundred dollars (\$100.00) for **each** principal officer, board member, agent, volunteer or employee.

According to RIGL 21-28.6-12. Compassion centers, Section 7i, (i) All registry identification card applicants shall apply to the state police for a national criminal background identification records check that shall include with fingerprints submitted to the federal bureau of investigation.

- To obtain an NCIC/AFIS report, please contact the Rhode Island State Police at 401-444-1110 and schedule and appointment.



Application for Compassion Center Staff

Name: 	<input type="text"/> <small>First Name</small> <input type="text"/> <small>Middle Name</small> <input type="text"/> <small>Surname, (Last Name)</small>
Social Security Number	<input type="text"/> - <input type="text"/> - <input type="text"/> <small>U.S. Social Security Number</small>
Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>
Home Address Please provide your principal address of residence. It is your responsibility to notify the board of all address changes.	<input type="text"/> <small>1st Line Address (Apartment/Suite/Room Number, etc.)</small> <input type="text"/> <small>Second Line Address (Number and Street)</small> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <small>City State Zip Code</small> <input type="text"/> <input type="text"/> - <input type="text"/> <small>Home Phone Home Fax</small> <input type="text"/> <small>Email Address (Format for email address is Username@domain e.g. applicant@isp.com)</small>
Employer Address Please list the address of the compassion center in which you are associated.	<input type="text"/> <small>Name of Compassion Center</small> <input type="text"/> <small>1st Line Address (Apartment/Suite/Room Number, etc.)</small> <input type="text"/> <small>Second Line Address (Number and Street)</small> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <small>City State Zip Code</small> <input type="text"/> <input type="text"/> - <input type="text"/> <small>Business Phone Business Fax</small> <input type="text"/> <small>Email Address (Format for email address is Username@domain e.g. applicant@isp.com)</small>
Employer Affidavit Please have the employer sign this affidavit.	<p>"I hereby affirm that the person named in this application is affiliated with the Compassion Center listed in the Employer Address section of this application.</p> <p>Printed Name of Principal Officer or Authorized Designee _____</p> <p>Signature of Principal Officer or Authorized Designee _____ Date of Signature (MM/DD/YY) _____</p>

Applicant Affidavit

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

"I hereby affirm that I am the applicant named in this application, that I have made or read the contents hereof, and to the best of my knowledge and belief the foregoing statements and answers are true in substance and effect and are made in good faith." I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature of Applicant _____

Date of Signature (MM/DD/YY) _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp) _____

Signature of Notary _____

Notary Seal

Notary No/Commission No. _____

Commission Expiration Date (MM/DD/YY) _____