



**Center for Professional Licensing
Medical Marijuana Program
3 Capitol Hill, Room 105A
Providence, RI 02908-5097**

Minor Form

Declaration of Person Responsible for a Minor to Participate

The custodial parent or legal guardian must complete all sections of this form to comply with the requirements of the Rhode Island Medical Marijuana Act. This form is required to be submitted with the Patient Application if the patient is a younger than 18. Attach this form to the Patient Application and mail the completed forms to the address above.

Patient name and information

Full Name	
Address (Apartment/Suite/Room Number, etc.)	
Address (Number and Street)	
City	State ZIP Code
Phone	
Email	

Date of birth

Month	Day	Year
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Would you like to be notified of any clinical studies about marijuana's risk or efficacy? Yes No
(These studies may be conducted in or outside of Rhode Island.)

I _____, do here by declare:
Custodial Parent or Legal Guardian's Name

1. I am the Custodial Parent or Legal Guardian, with the responsibility for healthcare decisions, for:

Patient's Name

- 2. The patient's attending practitioner has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana.**
- 3. I consent to the use of marijuana by the patient for medical purposes.**
- 4. I agree to serve as the patient's designated caregiver and/or authorized purchaser by completing the caregiver and/or authorized purchaser application. (See pages 7 and 8 of Patient Application.)**
- 5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the patient.**

Custodial Parent/Legal Guardian's Signature

Date

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation.



Name of Notary (print or stamp)	Signature of Notary	Notary/Commission number	Commission expires on:
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