Mississippi Medical Cannabis Program
Designation of Caregiver

1. This form is to be completed by the parent or legal guardian of the minor patient (under age 18); or by an adult patient (age 18 or older) who wishes to designate a licensed caregiver.
2. Patients must already be registered and approved for participation in the MS Medical Cannabis Program.
3. This form is required to complete a caregiver license application and be approved for a caregiver license.

SWORN to and subscribed before me, this the _____ day of _____, 20____.

NOTARY PUBLIC_____

Please stamp below

Patient Information

The patient is *(select one):*

◯ Minor Patient ◯ Adult Patient ◯ Temporary Minor Patient ◯ Temporary Adult Patient

First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yyyy)

Current Physical Street Address | APT# | City | State | ZIP

County | Medical Cannabis Patient Number

Caregiver Information

First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yyyy)

Current Physical Street Address | APT# | City | State | ZIP

County | Phone # | Email Address

Relationship with Patient *(select one):*

◯ Caregiver of adult patient who is a family member or assistant who regularly looks after the adult patient

◯ Custodial parent of minor patient

◯ Legal guardian of minor patient (must include documentation in application)

SECOND CAREGIVER *(OPTIONAL FOR MINOR PATIENTS)*

First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yyyy)

Current Physical Street Address | APT# | City | State | ZIP

County | Phone # | Email Address

Relationship with Patient *(select one):*

◯ Custodial parent of minor patient ◯ Legal Guardian of minor patient (must include documentation in application)

ATTESTATION **By my signature below, I attest to the following:**

FOR ADULT PATIENTS

- I understand I am designating the individual identified above as my caregiver;
- I understand this individual cannot possess or purchase medical cannabis on my behalf until he or she has been approved for and received a caregiver identification card issued by MSDH; and
- I understand I can only have one designated caregiver at any given time.

Adult Patient Signature (If applicable)

Date (mm/dd/yyyy)

ATTESTATION **By my signature below, I attest to the following:**

FOR MINOR PATIENTS

- I am a custodial parent or legal guardian of the minor patient.
- I understand that if I am a legal guardian, I will need to provide official documentation proving my legal guardianship in my online application.
- I understand I will not receive a caregiver's identification card until I complete a caregiver application and am approved for an identification card.

Parent/Legal Guardian Signature (If applicable) | Date (mm/dd/yyyy)

Parent/Legal Guardian Signature (If applicable) | Date (mm/dd/yyyy)