Arkansas Medical Marijuana Program
Qualifying Patient Checklist

For New Patient Applications and Renewals

PLEASE PRINT CLEARLY. Ensure all forms are complete. Incomplete applications or applications with errors will be returned to applicant. All forms must have the original signatures. Illegible applications may delay processing
Note: Applying online is easy. Please visit https://mmj.adh.arkansas.gov/ to apply online.

Keep a copy of all application documents for your records including your Arkansas ID

- ☐ Patient Registry Application form filled out completely and accurately.
- ☐ Physician Written Certification Form filled out completely by an Arkansas licensed medical physician or osteopathic physician (DO). A new form is needed each time you renew. This form must be received by the Arkansas Department of Health within thirty days of the physician's signature. If a caregiver is needed, the form must indicate that the patient is physically disabled or a under 18; caregivers must apply separately and pay a separate fee.
- ☐ A current copy of the front of your Arkansas Driver's License or State ID issued by the Department of Motor Vehicles PLEASE MAKE SURE IT IS CLEAR AND VISIBLE.
- ☐ Check or money order for $50 for the non-refundable fee. Payment should be made payable to ADH. **DO NOT MAIL CASH**.

Mailing Address: **Arkansas Department of Health**
4815 West Markham, Slot 50
Little Rock AR, 72205

Application processing time is up to 14 working days from the date we receive your application and payment.

Website: https://www.healthy.arkansas.gov/programs-services/topics/medical-marijuana

Telephone Number: 501-682-4982 or toll-free at 1-833-214-8619. We are open Monday through Friday from 8:00 a.m. to 4:30 p.m. except for state holidays.

Arkansas Department of Health

Medical Marijuana Registry Patient Application

for new applications and renewals

To apply online visit https://mmj.adh.arkansas.gov

Patient Information

First Name	Middle Name	Last Name	Area code & Phone #	E-mail

Mailing Address ☐ Check if homeless

Street Number and Street (or PO Box)			
Unit Type (Apt, Unit, Suite, etc.)	Unit Number		
City	State	Zip	County

Residence Address (If different from mailing address)

Street Number and Street (or PO Box)			
Unit Type (Apt, Unit, Suite, etc.)	Unit Number		
City	State	Zip	County

Patient Identifiers

Date of Birth (mm/dd/yyyy)	Arkansas DL or ID number	ID Expiration (mm/dd/yyyy)	Sex	Race	Last 4 digits of social security

☐ Yes ☐ No Are you an active-duty member of the Arkansas National Guard or the United States military?

By signing, I, the patient pledge not to divert marijuana to anyone who is not allowed to possess marijuana under the Arkansas Medical Marijuana Amendment of 2016. (Must be signed by the parent/guardian if under 18)

Signature	Date

Print Name

Optional Caregiver(s) Information. **Required** if the patient is under 18.

1 First Name	Middle Name	Last Name	DOB
2 First Name	Middle Name	Last Name	DOB
3 First Name	Middle Name	Last Name	DOB

The Physician Written Certification MUST be marked either under 18 or physically disabled before a caregiver application can be processed. Caregivers must complete a separate Caregiver application packet and pay a separate fee.

Send this completed form along with:

1. A completed Physician Written Certification form
2. A copy of the front of your Arkansas Driver's License or Dept. of Motor Vehicles issued Arkansas State ID
3. A $50 **non-fundable** check or money order payable to:
   Arkansas Department of Health
   4815 W Markham, Slot 50
   Little Rock, AR 72205

Application processing time is 14 working days from the date we receive your application and payment. Incomplete applications and applications with errors will be returned for corrections and will take longer.

Arkansas Department of Health

Medical Marijuana Physician's Written Certification

To apply online visit https://mmj.adh.arkansas.gov

Patient Information			
First Name	Middle name		Last Name
Street Number and Street name (or PO Box)		Unit Type (Apt, Lot, Suite, etc)	Unit Number
City	State	Zip	County
Date of Birth (mm/dd/yyyy)	Under the age of 18? ☐ Yes ☐ No		Physically Disabled? ☐ Yes ☐ No

☐ I hold a valid, unrestricted, existing license to practice as a medical physician or osteopathic physician in Arkansas and have been issued a registration from the U.S. DEA to prescribe controlled substances.

☐ It is my professional opinion, after having completed an assessment* of the patient's medical history and current medical condition in the course of a physician patient relationship, the patient has a qualifying medical condition identified below.

Select the qualifying medical condition(s). Handwritten conditions will not be accepted:

- ☐ Cancer
- ☐ Glaucoma
- ☐ Positive status for human immunodeficiency virus/acquired immune deficiency syndrome
- ☐ Hepatitis C
- ☐ Amyotrophic lateral sclerosis
- ☐ Tourette's syndrome
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Post-traumatic stress disorder
- ☐ Severe arthritis
- ☐ Fibromyalgia
- ☐ Alzheimer's disease
- ☐ Cachexia or wasting syndrome
- ☐ Peripheral neuropathy
- ☐ Intractable pain, which is pain that has not responded to ordinary medications, treatment or surgical measures for more than six (6) months
- ☐ Severe nausea
- ☐ Seizures, including without limitation those characteristic of epilepsy
- ☐ Severe and persistent muscle spasms, including without limitation those characteristic of multiple sclerosis

Issue Registry Card for: ☐ 12 months ☐ Less than 12 months: ___ Months ___ Weeks

Physician Information			
First Name	Middle Name	Last Name	Arkansas Medical License Number
Street Number and Street name (or PO Box)		Unit Type (Apt, Lot, Suite, etc)	Unit Number
City	State	Zip	County
Phone	By **signing** below, I do hereby attest that this information is true, accurate and complete		Date

This form must be received by the Arkansas Department of Health with payment and a completed application within 30 days of the physician's signature.

Parent/legal guardian/legal custodian of minor patient – REQUIRED if the patient is under 18	
As the parent/legal guardian or custodian of this minor patient, I am aware of the diagnosis risks, benefits and consent to the minor patient's use of marijuana.	
Signature	Date
Print Name	

*Pursuant to Act 1112 of 2021, physician written re-certification assessments may be done via telehealth.