DEPARTMENT OF HEALTH

Designated Caregiver Background Check Informed Consent

MINNESOTA MEDICAL CANNABIS PATIENT REGISTRY

Instructions

Once you have filled out this form:

1. Write a check for $15 payable to the MN Bureau of Criminal Apprehension.
2. Place a stamp on an empty envelope addressed to:
   Office of Medical Cannabis
   PO Box 64975
   St Paul, MN 55164-0975
3. Put this completed form, the $15 check, and the empty stamped and addressed envelope in a separate envelope, and *mail all three items to*:
   Bureau of Criminal Apprehension
   CHA Unit
   1430 Maryland Ave. E.
   St. Paul, MN 55106

If they have not done so already, please have the patient add your name, email address, and telephone number to their patient account online. Once they do, you will receive your caregiver enrollment link via email.

Caregiver Applicant Information

I am sending this form to start the process of becoming a designated caregiver in the Minnesota medical cannabis patient registry under Minnesota Statutes section 152.27, subdivision 4. (Please print all responses.)

Last Name of Caregiver Applicant: _____

First Name: _____ **Middle Name** (full): _____

Maiden, Alias, or Former Name: _____

Date of Birth (month/day/year): _____ **Sex** (M or F): _____

Social Security Number (optional): _____

Telephone Number (optional): _____

Note: Providing direct contact information will help ensure your background check is matched with the correct patient.

I authorize the Minnesota Bureau of Criminal Apprehension to disclose all criminal history record information to the Minnesota Department of Health's Office of Medical Cannabis for the purpose of determining my eligibility to be registered as a designated caregiver in the Minnesota medical cannabis patient registry under Minnesota Statutes section 152.27, subdivision 4. If I do not consent to this check or if I am not eligible under terms of the statute, I will not be enrolled as a designated caregiver in the Minnesota medical cannabis program.

The expiration of this authorization shall be one year from the date of my signature.

Applicant Signature _____**Date** _____

Minnesota Department of Health
Office of Medical Cannabis
PO Box 64975
St. Paul, MN 55164-0975
651-201-5598
health.cannabis@state.mn.us
www.health.state.mn.us

01/25/2023

To obtain this information in a different format, call: 651-201-5598.