STATE OF CONNECTICUT

DEPARTMENT OF CONSUMER PROTECTION · DRUG CONTROL DIVISION

CULTIVATING CAREGIVER LICENSE APPLICATION

Medical Marijuana Program · Chapter 420f of the General Statutes · Type or print clearly in ink

SECTION 1: APPLICANT INFORMATION

Provide your legal name exactly as it appears on your state-issued photographic identification.

Applicant's Legal Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)
Residential Street Address | City | State | ZIP	
Mailing Address (if different) | City | State | ZIP	
Telephone Number | E-mail Address	MMP Caregiver Registration No. (if any)

SECTION 2: TYPE OF APPLICATION

Check one.

☐ **NEW** license application. Complete all sections.
☐ **RENEWAL** of an existing cultivating caregiver license. Complete all sections.
☐ **AMENDMENT** to an existing license. Complete Sections 1, 4, 5, 6 (as applicable), 8 and 9.

SECTION 3: ELIGIBILITY

You must be able to check every box in this section. If you cannot, you are not eligible for a license at this time.

☐ I am twenty-one (21) years of age or older.
☐ I am a resident of the State of Connecticut.
☐ I have not been convicted of a violent felony, or of a felony involving the sale of a controlled substance to a minor.
☐ I consent to a state and national criminal history records check conducted in accordance with section 29-17a of the general statutes.
☐ I do not hold, and am not a backer of, a cultivator, micro-cultivator, producer, retailer, hybrid retailer or dispensary facility license.
☐ I have completed the Department's no-cost cultivation, handling and storage education module. Completion date: _____

FEDERAL REGISTRATION IS OPTIONAL. Connecticut law does not require a cultivating caregiver licensee to apply for or hold any federal registration. Applicants should be aware that federal registration may carry federal inspection obligations.

SECTION 4: DESIGNATED QUALIFYING PATIENTS

List each qualifying patient who has designated you as their cultivating caregiver. A completed Patient Designation Form (DCP-MMP-CCL-2) signed by the patient must accompany this application for each patient listed. Maximum five (5).

1. Patient's Legal Name	Patient MMP Registration No.	Designation Form Attached
2. Patient's Legal Name	Patient MMP Registration No.	Designation Form Attached
3. Patient's Legal Name	Patient MMP Registration No.	Designation Form Attached
4. Patient's Legal Name	Patient MMP Registration No.	Designation Form Attached
5. Patient's Legal Name	Patient MMP Registration No.	Designation Form Attached

Total number of designated qualifying patients listed above: _____ Maximum permitted: 5

SECTION 5: CULTIVATION SITE

A cultivation site must be the primary residence of the cultivating caregiver or of a designated qualifying patient. You may list one cultivation site only.

Cultivation Site Street Address | City | State | ZIP		
Property Owner's Name (if you own the property, enter "Self")	Property Owner's Telephone	Written Owner Consent Attached (if not owner)

At this site I will cultivate:

☐ **Indoors**, within a dwelling unit or fully enclosed accessory structure.

☐ **Outdoors**, on the grounds of the primary residence. If checked, complete the outdoor requirements below.

Outdoor cultivation requirements — check each that applies to your site:

☐ The cultivation area is not visible at ground level from any adjacent public street, sidewalk, park or neighboring residential property.

☐ The area is enclosed by a fence, wall, hedge or similar barrier of not less than six (6) feet in height, or by an accessory structure or greenhouse.

☐ The enclosure is secured by a lock or comparable device against entry by any person other than a resident of the primary residence, a designated qualifying patient, or me.

☐ I will take reasonable measures to mitigate odor, including siting and, for indoor cultivation, filtration.

SECTION 6: CULTIVATION LEVEL AND ANNUAL FEE

Select ONE tier. You may be licensed by plant count or by canopy, not both. Plant counts are additionally subject to the per-patient limits in section 5 of the authorizing act and to a total mature plant canopy of five hundred (500) square feet.

SELECT	CULTIVATION AUTHORITY	ANNUAL FEE	TIER
□	Up to 6 mature / 12 immature cannabis plants	$240	**A**
□	Up to 12 mature / 24 immature cannabis plants	$480	**B**
□	Up to 18 mature / 36 immature cannabis plants	$720	**C**
□	Up to 24 mature / 48 immature cannabis plants	$960	**D**
□	Up to 30 mature / 60 immature cannabis plants	$1,200	**E**
□	500 sq. ft. mature canopy / 1,000 sq. ft. immature canopy	$1,500	**F**

SECTION 7: SUPPLEMENTAL DOCUMENTS

Attach the following. Incomplete applications are not processed.

☐ Copy of state-issued photographic identification.

☐ Completed Patient Designation Form (DCP-MMP-CCL-2) for each patient listed in Section 4.

☐ Written consent of the property owner, if you are not the owner of the cultivation site.

☐ Certificate of completion for the cultivation, handling and storage education module.

☐ Criminal history records check authorization form.

SECTION 8: FEE

License fees are annual and are non-refundable. Fees are deposited in the Cannabis Regulatory and Investment Account and support administration of the program and the voluntary laboratory testing program.

☐ **FEE WAIVER REQUESTED.** I am a veteran as defined in section 27-103 of the general statutes, or I am the spouse, parent, child or legal guardian of a designated qualifying patient, and I am applying at Tier A.

Tier Selected (A–F)	Annual Fee Amount	Waiver Applied (Y/N)	Total Enclosed	Method of Payment

SECTION 9: ATTESTATION AND SIGNATURE

I understand and agree to provide documents, if requested, to clarify or support the information provided in this application. I understand that the Department may verify the information I have given, except as limited by the confidentiality provisions applicable to the Medical Marijuana Program. I affirm that if I have given incorrect or incomplete information, my license may be denied, suspended or revoked. I understand that I may not sell cannabis, advertise cannabis for sale, or transfer cannabis to any person other than a designated qualifying patient or that patient's caregiver. I certify that all answers and supporting information provided in this application are true, accurate and complete to the best of my knowledge.

Signature of Applicant	Date	Printed Name

SUBMIT THIS APPLICATION AND ANY FEE TO:
Department of Consumer Protection · Drug Control Division · Medical Marijuana Program
450 Columbus Boulevard, Suite 901, Hartford, CT 06103
Telephone: (860) 713-6066 · E-mail: dcp.mmp@ct.gov · Web: portal.ct.gov/dcp
License information is confidential and is not subject to disclosure under section 1-210 of the general statutes.

DRAFT — NOT AN OFFICIAL STATE FORM. This document is a model application prepared to accompany proposed legislation. No cultivating caregiver license exists under Connecticut law at this time. Contact information, form number and mailing address are placeholders and must be confirmed by the Department of Consumer Protection before any official use.

STATE OF CONNECTICUT

DEPARTMENT OF CONSUMER PROTECTION · DRUG CONTROL DIVISION

PATIENT DESIGNATION OF CULTIVATING CAREGIVER

Form DCP-MMP-CCL-2 · Attach to Form DCP-MMP-CCL-1 · One form per patient

SECTION 1: QUALIFYING PATIENT INFORMATION

To be completed by the qualifying patient. A separate form is required for each cultivating caregiver designation.

Patient's Legal Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)
Residential Street Address | City | State | ZIP	
MMP Patient Registration No.	Telephone Number | E-mail Address

SECTION 2: CULTIVATING CAREGIVER BEING DESIGNATED

Cultivating Caregiver's Legal Name	Cultivating Caregiver License No. (if issued)
Cultivation Site Street Address | City | State | ZIP	

SECTION 3: DESIGNATION

Read carefully before signing.

- ☐ I designate the person named in Section 2 as my cultivating caregiver, and I authorize that person to cultivate cannabis on my behalf for my palliative use.
- ☐ I understand that I may designate only ONE cultivating caregiver at a time.
- ☐ I understand that I may continue to cultivate cannabis myself and may continue to obtain cannabis from a dispensary facility or hybrid retailer.
- ☐ I understand that this designation may be revoked by me at any time, in writing, and that revocation takes effect upon filing with the Department.
- ☐ I understand that my cultivating caregiver may be reimbursed only for documented costs actually incurred, and may not sell cannabis to me or to anyone else.

SECTION 4: REVOCATION OF A PRIOR DESIGNATION

Complete only if revoking.

☐ I revoke my prior designation of the following cultivating caregiver:

Prior Cultivating Caregiver's Name	Prior Cultivating Caregiver License No.	Effective Date

SECTION 5: PATIENT SIGNATURE

I certify that the information provided on this form is true, accurate and complete. I understand that this designation will be filed with the Department of Consumer Protection and that the information provided is confidential and not subject to disclosure under section 1-210 of the general statutes.

Signature of Qualifying Patient	Date	Printed Name

If the qualifying patient is under eighteen (18) years of age or otherwise lacks legal capacity, this form must be signed by the patient's parent, guardian or person having legal custody.

Signature of Parent, Guardian or Legal Custodian	Date	Printed Name

DRAFT — NOT AN OFFICIAL STATE FORM. Model form prepared to accompany proposed legislation. Attach one completed copy to Form DCP-MMP-CCL-1 for each designated qualifying patient. Form numbers and agency contact details are placeholders.