FLANDREAU SANTEE SIOUX TRIBE
MEDICAL MARIJUANA PROGRAM

Recertification Renewal Application

This form is for active registered **Patients** and registered **Caregivers** who need a full recertification renewal of a Medical identification card. Completing this form is a full recertification renewal for patients that have had their cards for one year or whose card has expired. Full recertification renewal will require patients to go see their certifying health care professional for a new updated health care professional certification as well as additional documents.

As of now, medical marijuana renewal is required every 12 months. You'll need to renew it at least 30 days before the card's expiration date.

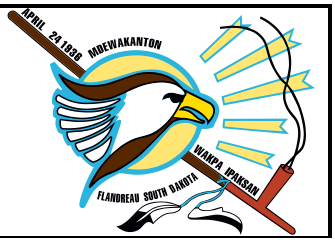
Instructions

1. Schedule an appointment with a certifying physician/APRN.
    a. Initial applications need a face-to-face in-person appointment.
    b. Renewal applicants may inquire with their provider's office for available appointments.
    c. Medical Card Secure online process
2. Submit your application to your certifying physician/APRN, when physician/APRN certifies your condition.
    a. Confirm that the patient is under your care.
    b. Provide the date that you examined the patient for the recertification;
    c. Confirm that you still have a bona-fide patient/physician relationship;
3. Fill out the Application. Please have the following documents ready.
    a. Update any other information to the extent it has changed from the previous year (e.g. if you or the patient has a new address).
    b. Valid Driver License, State ID issued by a state of the United States or a Valid Passport.
    c. Printed Physician Recommendation
4. Pay the application fee with Credit/Debit card or cash ($50.00 for a 1-year registration). **All fees are non-refundable.**
5. Patient can renew their Identification card **30 days prior** the Native Nations Cannabis Medical card expiration.
6. Before submitting your application, if any information is not correct, you need to contact the Native Nations Cannabis Medical Card to make the corrections.

Caregivers:

1. Provide a photo ID
    a. Valid Driver License, State ID issued by a state of the United States of a Valid Passport.
2. Pay the application fee with Credit/Debit card or cash ($50.00 for a 1-year registration). **All fees are non-refundable.**
3. Caregiver can renew their Identification card **30 days prior** to the Native Nations Cannabis Medical Card Expiration.

FLANDREAU SANTEE SIOUX TRIBE
MEDICAL MARIJUANA PROGRAM
Application Form for Medical Card Identification



Section A: Cardholder Information		
Legal First Name	Middle Initial	Legal Last Name
Date of Birth (MM/DD/YY)	Telephone Number	
Current Mailing Address including Apartment/Suite/Lot #		
City	State	Zip Code

Section B: Caregiver Information (required only if designating a caregiver)		
Legal First Name	Middle Initial	Legal Last Name
Date of Birth (MM/DD/YY)	Telephone Number	
Current Mailing Address including Apartment/Suite/Lot #		
City	State	Zip Code
Other Names Used by Caregiver (maiden Name(s), Nicknames, etc.)		
Relationship to Patient:		

Section C: Patient/Caregiver Signature & Date

I attest the information I provided is true and accurate and that I will comply with the requirements of the Native Nations Medical Marijuana Program. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the Native Nations Medical Marijuana Program to print on my Native Nation Cannabis Medical Card.

Signature of Patient:_____ **Date:**_____

I attest the information I provided is true and accurate and that I will comply with the requirements of the Native Nations Medical Marijuana Program. I agree to serve as the patient's primary caregiver, am at least 21 years old, have no convictions that disqualify me from serving as primary caregiver, and authorize the Nation Nations Cannabis Medical Cards Program to use the information provided in this application to perform a criminal background check. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the Native Nations Medical Marijuana Program to print on my Native Nation Cannabis Medical Card.

Signature of Caregiver:_____**Date**:_____

For Official Use Only

Fee Paid_____ Copy of Proof of Identification_____ ID #_____

Physical Form Completed_____ Payment Type: Cash, Check, CC Mo/ck#_____

Date Issued:_____ Issued by:_____

FLANDREAU SANTEE SIOUX TRIBE
MEDICAL MARIJUANA PROGRAM
Physician Certification Form

Section A: Certifying Physician Information (name as it appears on medical license)

Legal First Name	Middle Initial	Legal Last Name

Current Mailing Address including Apartment/Suite/Lot #

City	State	Zip Code	Telephone Number

Physician License Number (enter only 10 digits)

M.D._ _ _ _ _ _ _ _ _ _ **D. O.** _ _ _ _ _ _ _ _ _ _

Section B: Patient Information

Legal First Name	Middle Initial	Legal Last Name

Date Of Birth (MM/DD/YY)

Section C: Patient's Debilitating Medical Condition (s)

This patient has been diagnosed with the following debilitating medical condition(s): (A minimum of one box must be checked in at least one of the following categories.)

Category A

- ☐ Cancer
- ☐ Glaucoma
- ☐ HIV Positive
- ☐ AIDS
- ☐ Hepatitis C
- ☐ Arthritis
- ☐ Crohn's Disease
- ☐ Migraines
- ☐ Anorexia
- ☐ Diabetes

Category B

A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following:

- ☐ Depression
- ☐ Chronic Pain
- ☐ Severe Nausea
- ☐ Seizures (including but not limited to those characteristic of epilepsy)
- ☐ Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of multiple sclerosis)

Category C

- ☐ Post-Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Rheumatoid Arthritis
- ☐ Spinal Cord Injury
- ☐ Anxiety Disorder
- ☐ Inflammatory Bowel Disease
- ☐ Parkinson's Disease
- ☐ Tourette's Syndrome
- ☐ Autism
- ☐ Severe Pain
- ☐ Cerebral Palsy

Section D: Certification, Signature, & Date

By Signing below, I attest that the information entered on this certification is true and accurate. I attest that I am in compliance with Native Nations Medical Marijuana Program and associated administrative rules and have bona fide physician-patient relationship with this patient. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation.

Signature of Physician:_____ **Date:**_____

For Official Use Only

Fee Paid_____ Copy of Proof of Identification_____ ID #_____

Physical Form Completed_____ Payment: Cash, Check, CC Mo/Check #_____

Date Issued:_____ Issued By:_____