Designated Caregiver Background Check Informed Consent
Minnesota Medical Cannabis Patient Registry

Once you have completed 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 64882
   St Paul, MN 55164

3. Send this form, the check and the stamped & addressed envelope to:
   Bureau of Criminal Apprehension
   CHA Unit
   1430 Maryland Ave. E.
   St. Paul, MN 55106

4. Please have the patient add your name, email address and telephone number to their patient account. Once they do, you will receive your caregiver registry enrollment link via email.

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.

Last Name of Caregiver Applicant (please print): _____

First Name (please print): _____

Middle (full)(please print): _____

Maiden, Alias or Former(please print): _____

Date of Birth: _____ **Sex** (M or F): _____
Month/Day/Year

Social Security Number (optional): _____

Telephone Number (optional): _____
Providing direct contact information will help to 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.

Signature of Applicant _____ **Date** _____