EBCI CANNABIS CONTROL BOARD
APPLICATION FOR MEDICAL CANNABIS PATIENT CARD

Please complete this form legibly in black or blue ink.

Please check one:
New Application: _____ Renewal: _____ Information Update: _____

Full Legal Name: _____

Maiden/Other Name (*if applicable*): _____

Date of Birth: _____ Gender: _____

Physical Address: Street: _____

City/Town: _____ State: _____ Zip: _____

Mailing Address: Street/P.O. Box:_____

(*if different*) City/Town: _____ State: _____ Zip: _____

Telephone Number: _____ Email: _____

EBCI Enrollment Number (*if applicable*): _____
(*please provide a copy of your EBCI enrollment card*)

Full Legal Name of Designated Primary Caregiver* (*if applicable*):
_____
**A designated primary caregiver is a person who helps you access healthcare and perform other activities of daily living. This is a person you have named in a healthcare power of attorney to act on your behalf for healthcare purposes.*

Relation to Designated Primary Caregiver: _____

Please complete all applicable sections of this application. Please provide a copy of government-issued identification, written documentation of a chronic or debilitating medical condition listed in 17 CAR 14.04(c), applicable application fee, and a copy of your EBCI enrollment card (if applicable) with this application.

By submitting this application, I represent to the EBCI Cannabis Control Board that all information contained herein is true and accurate and that I will update this information whenever any changes occur. I understand that medical cannabis patient cards and the use thereof are governed by the laws of the Eastern Band of Cherokee Indians, including Cherokee Code Chapter 17 and Title 17 of the Cherokee Administration Regulations.

_____ _____
Signature Date