



Virginia Department of
Health Professions
Board of Pharmacy

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Henrico, Virginia 23233
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www.dhp.virginia.gov/pharmacy

Application for Registration as a Practitioner for Medical Cannabis

Application Fee: \$50.00

The required non-refundable fee must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant - Please provide the information requested below. (Print or Type)

| | | | | |
|--|---|---------------|----------|------------|
| Name: Last | First | Middle/Maiden | | |
| Street Address (official address of record**) | City | State | Zip Code | Tel Number |
| Street Address | City | State | Zip Code | Tel Number |
| Date of Birth ____ / ____ / ____ | Social Security Number or Virginia DMV Control Number | | | |
| Email Address | | | | |
| Do you hold a Current Active Medicine and Surgery, Osteopathy and Surgery, Physician Assistant, or Nurse Practitioner license from the Commonwealth of Virginia? | MD, DO, PA, LNP License Number | | | |

**In accordance with § 54.1-2400.02 of the Code of Virginia, an applicant must provide an official address of record. An applicant may choose to provide a second address for public dissemination, which may be a work address, a post office box, or a home address. If an applicant does not provide a second address, his official address of record shall also be used as the public address for the purpose of public dissemination.

ANSWER THE FOLLOWING QUESTIONS: Attach additional page if needed as well as any related documents

| | YES | NO |
|--|--------------------------|--------------------------|
| 1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, provide full explanation including if you have been directed to seek treatment for your conduct or behavior. | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| _____ | | |
| | YES | NO |
| 2. Within the past five years, have you been disciplined by any entity? If yes, please provide a full explanation and any associated orders or letters from entity. | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| _____ | | |

| | YES | NO |
|---|--------------------------|--------------------------|
| 3. Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving). Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider requesting your provider send this documentation directly to the Board. _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant's written statement: (the following must be filled in and signed)

I _____ hereby certify and affirm that the statements contained in this application for registration as a Practitioner for Medical Cannabis in the Commonwealth of Virginia are true and accurate in every respect. Additionally, by signing below, I attest that I have carefully read the Virginia Regulations Governing Pharmaceutical Processors. Further, I hereby agree to abide by and remain current with the applicable Virginia laws and regulations governing this practice.

| | |
|--|--|
| | |
|--|--|

Signature of Applicant: _____ Date: _____

FOR OFFICE USE ONLY:

| | | | | |
|-----------------|-----------------------------------|--------------|----------------|-------------------|
| Date Processed: | Practitioner Registration Number: | Reviewed by: | Date Reviewed: | Date Sent to PMP: |
| | | | | |