Virginia Department of
Health Professions
Board of Pharmacy

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4456 (Tel)
(804) 527-4472 (Fax)
cbd@dhp.virginia.gov
www.dhp.virginia.gov/pharmacy

Application for Registration as a Registered Agent for Cannabis Oil

Application Fee: $25.00

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

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

Name: Last	First	Middle/Maiden
Street Address		
City	State	Zip Code
Date of Birth ____ ____ / ____ ____ / ____ ____ ____ ____	Social Security Number or Virginia DMV Control Number	
Email Address	Telephone Number	

PLEASE ANSWER THE FOLLOWING QUESTIONS:		
NOTE: A person may act as the registered agent for no more than 2 registered patients.	**YES**	**NO**
1. Has a patient, or the parent or legal guardian of a patient who is a minor or an incapacitated adult, designated you to serve as the patient's registered agent?	☐	☐
Does the patient have a current written certification from a practitioner to possess cannabis oil and a current Cannabis Oil Patient Registration issued by the Board of Pharmacy? If no, the application will not be processed.	☐	☐
If yes, provide the following information for Patient Number 1: Patient's Full Name: ______________________ Patient's Address: ______________________ ______________________ Patient's Date of Birth (mm/dd/yyyy): __ __/__ __/__ __ __ __ Patient's Registration Number:______________________ Name of person designating you to serve as registered agent:______________________ Person designating you is the ☐ patient ☐ parent/legal guardian.		
If yes, provide the following information for Patient Number 2: Patient's Full Name: ______________________ Patient's Address: ______________________ ______________________ Patient's Date of Birth (mm/dd/yyyy): __ __/__ __/__ __ __ __ Patient's Registration Number:______________________ Name of person designating you to serve as registered agent:______________________ Person designating you is the ☐ patient ☐ parent/legal guardian.		

2.	Have you had a registration of a patient, parent, legal guardian or registered agent for cannabis oil denied, suspended or revoked by the board in the previous six months?	**YES** ☐ **NO** ☐
3.	By entering my initials, I understand that I must submit proof of identity and a copy of each patient's written certification for the use of cannabis oil signed by a registered practitioner (DO NOT SEND THE ORIGINAL DOCUMENTATION).	**INITIALS** ______

Applicant's Certification: (the following must be signed and dated)

I certify by entering my signature below: I am the person applying for registration as a registered agent and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

Printed Name of Applicant	Date
Signature of Applicant	Date