

# Medical Cannabis Voluntary Identification Card Program

## PRIMARY CAREGIVER CERTIFICATION DESIGNATION SECTION

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I, \_\_\_\_\_, do hereby certify that  
Print patient's name

\_\_\_\_\_  
Print full name of caregiver

\_\_\_\_\_  
Street address of caregiver

\_\_\_\_\_  
City/Zip Code

\_\_\_\_\_  
Telephone Number of caregiver

is my primary caregiver. He/She consistently assumes, on my behalf, responsibility for my housing, health care assistance and safety.

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature of patient (Sign in the presence of a Medical Cannabis ID Program employee unless special arrangements are made).

I, \_\_\_\_\_, do hereby certify that I am the primary  
print primary caregiver's name

caregiver for \_\_\_\_\_  
print full name of patient

I consistently assume, on his/her behalf, responsibility for his/her housing, health care, or safety.

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature of primary caregiver (Sign in the presence of a Medical Cannabis ID Program employee)

This form is for implementation of Proposition 215, the Compassionate Use Act of 1996, and Measure B. This form does NOT confer legal guardianship, durable power of medical care or other implication.

The purpose of this voluntary identification card program is to help law enforcement officers identify individuals whose possession of medical cannabis is permissible under Health and Safety Code Section 11362.5. This form shall not be used to assist anyone in obtaining or gaining access to cannabis.