



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 DIVISION OF COMMUNITY AND PUBLIC HEALTH
**MISSOURI HEMP EXTRACT REGISTRATION CARD
 APPLICATION**

Date Received

APPLICANT INFORMATION (please print or type)

“Applicant” is a Missouri resident eighteen years of age or older (1) with intractable epilepsy or (2) who is the parent or legal guardian responsible for the medical care of a minor with intractable epilepsy.

Applicant Full Legal Name (last name, first name, and middle name) (include suffixes, i.e., Junior, Senior, II, III, etc.)		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip Code
County	Telephone Number	Email Address		
Race <input type="checkbox"/> Asian/Native Hawaiian/Pacific Islander <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaskan Native		White <input type="checkbox"/> Mixed Race <input type="checkbox"/> Other		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

MINOR INFORMATION (please print or type)

Minor Full Legal Name (last name, first name, and middle name) (include suffixes, i.e., Junior, Senior, II, III, etc.)		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip Code
County				
Race <input type="checkbox"/> Asian/Native Hawaiian/Pacific Islander <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaskan Native		White <input type="checkbox"/> Mixed Race <input type="checkbox"/> Other		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

This application must be accompanied by all of the following:

- A copy of the applicant’s valid photo identification
- Missouri Hemp Extract Registration Card Neurologist Certification
- Copy of a record of the neurologist’s evaluation and observation relating to the individual’s treatment for intractable epilepsy

Submit this application and the additional required documents referenced above to:

Department of Health and Senior Services
 Division of Community and Public Health
 P.O. Box 570
 Jefferson City, MO 65102-0570

APPLICANT’S SIGNATURE (original signature required)

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