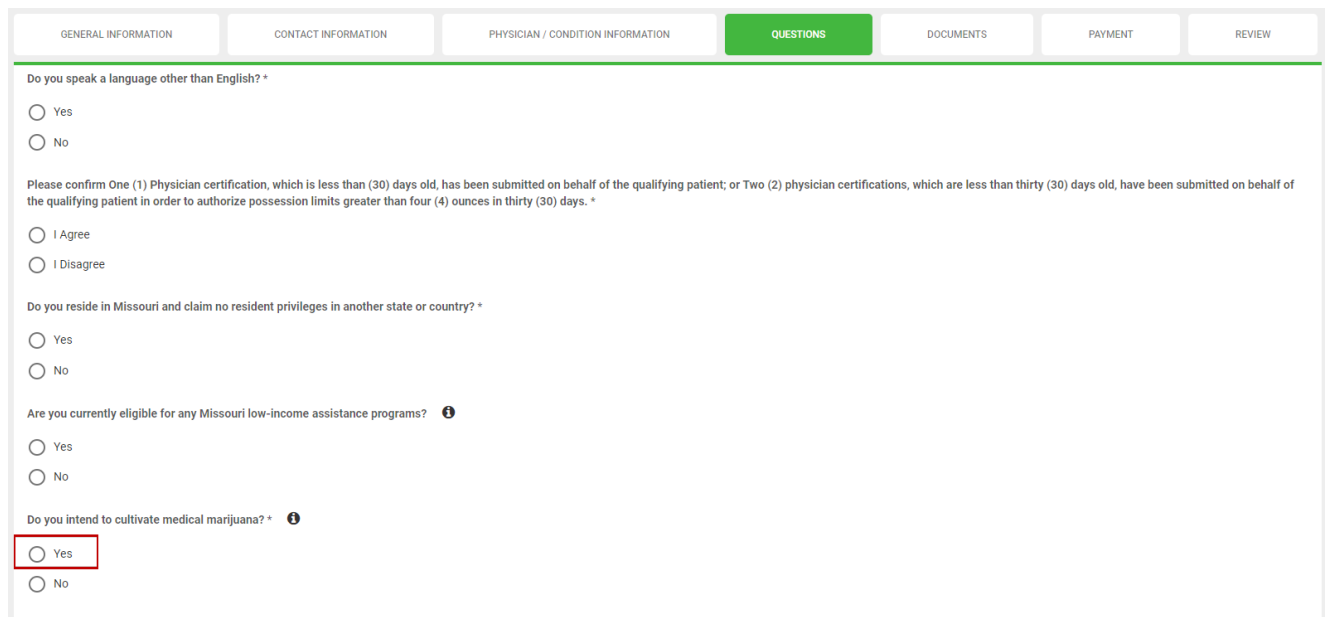


Providing Cultivation Details

Note: It is recommended that you use Google Chrome as your internet browser because other browsers may not work properly with the Patient Registry website.

1. Navigate to the **Questions** tab and answer the general patient questions.
2. If you would like to home cultivate, click **'Yes'** to answer the question **"Do you intend to cultivate medical marijuana?"**. If you do not want to home cultivate, click **'No'**.



GENERAL INFORMATION CONTACT INFORMATION PHYSICIAN / CONDITION INFORMATION **QUESTIONS** DOCUMENTS PAYMENT REVIEW

Do you speak a language other than English? *

Yes
 No

Please confirm One (1) Physician certification, which is less than (30) days old, has been submitted on behalf of the qualifying patient; or Two (2) physician certifications, which are less than thirty (30) days old, have been submitted on behalf of the qualifying patient in order to authorize possession limits greater than four (4) ounces in thirty (30) days. *

I Agree
 I Disagree

Do you reside in Missouri and claim no resident privileges in another state or country? *

Yes
 No

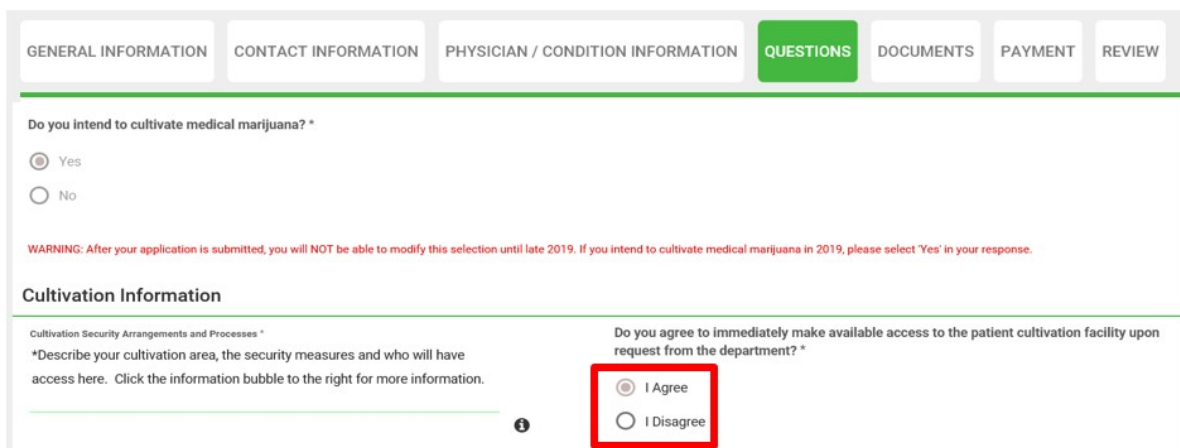
Are you currently eligible for any Missouri low-income assistance programs? ⓘ

Yes
 No

Do you intend to cultivate medical marijuana? * ⓘ

Yes
 No

3. You must answer the question **"Do you agree to immediately make available access to the patient cultivation facility upon request from the department?"**. Click **'I Agree'**.



GENERAL INFORMATION CONTACT INFORMATION PHYSICIAN / CONDITION INFORMATION **QUESTIONS** DOCUMENTS PAYMENT REVIEW

Do you intend to cultivate medical marijuana? *

Yes
 No

WARNING: After your application is submitted, you will NOT be able to modify this selection until late 2019. If you intend to cultivate medical marijuana in 2019, please select 'Yes' in your response.


Cultivation Information

Cultivation Security Arrangements and Processes *

*Describe your cultivation area, the security measures and who will have access here. Click the information bubble to the right for more information.


Do you agree to immediately make available access to the patient cultivation facility upon request from the department? *

I Agree
 I Disagree

- Click the **Information icon**  to read the rules and requirements for your home cultivation facility. After reading these rules and requirements, close the information box.
- In the **Cultivation Security Arrangements and Processes** field, enter a description of your home cultivation area, including what security measures you will have in place, who will have access, and those who will be sharing the facility with you.

Cultivation Information

Cultivation Security Arrangements and Processes *

Describe your home cultivation facility area, what security measures you will have in place, who will have access, and those who will be sharing the facility with you. 

167 / 500

Do you agree to immediately make available access to the patient cultivation facility upon request from the department? *

I Agree

I Disagree

- In the Cultivation Address section, enter the **Street, City, County, State,** and **Zip Code** of your home cultivation facility.
- Click **'Verify Address'** to verify the address you have entered.

Cultivation Address

Street *

Unit No. / Apt No.

City *


County *

State *

Zip Code *

Address Verified? * No


- If your cultivation facility will be shared, click **'Yes'** to answer the question **'Will this cultivation facility be shared?'**.
- If you answered **'Yes'**, enter the **Name of Patient/Caregiver** and click **'Save Record'**.
- If you want to add additional Patients or Caregivers, click **'+ Add New Record'**.

Will this cultivation facility be shared? * 

Yes

No

Patient/Caregiver Details

Name of Patient/Caregiver * 

License number of Patient/Caregiver

11. If you have more than one Patient or Caregiver listed and you want to delete one of them, click **'Remove Record'** on the Patient or Caregiver you want removed.

Patient/Caregiver Details

Name of Patient/Caregiver :Jane Doe

License number of Patient/Caregiver :

[✖ REMOVE RECORD](#) [✔ EDIT RECORD](#) [+ ADD NEW RECORD](#)

Name of Patient/Caregiver :JoJo Doe

License number of Patient/Caregiver :

[✖ REMOVE RECORD](#) [✔ EDIT RECORD](#) [+ ADD NEW RECORD](#)

12. Click **'Yes'** to answer the question: **Do you attest that the information provided in this application is true and correct?**

13. Enter today's date as your **Signature Date**.

14. To continue with the next tab and filling out the rest of the application, click **'Save & Next'**.

Do you attest that the information provided in this application is true and correct? *

Yes

No

Signature Date *
Signature Date

This field is required.

SAVE

SAVE & NEXT

CANCEL