CABINET FOR HEALTH AND FAMILY SERVICES
KENTUCKY MEDICAL CANNABIS PROGRAM
APPLICATION FOR REGISTRY IDENTIFICATION CARD

DESIGNATED CAREGIVER APPLICANT SIGNATURE PAGE

I hereby verify and affirm that all of the information provided in and with this Application for a Registry Identification Card is true and accurate. I understand that if the Cabinet for Health and Family Services later determines any of the information provided in the Application for a Registry Identification Card to be false, misleading, or inaccurate, the Cabinet may suspend or revoke any registry identification card issued to me.

I agree to be designated as the caregiver for the registered qualified patient identified in my application and pledge not to divert medicinal cannabis to anyone other than the registered qualified patient to whom I am connected through the Cabinet's registration process. I understand the potential penalties for unlawfully diverting medicinal cannabis, including criminal prosecution and revocation of any registry identification card issued by the Cabinet.

_____
Printed Name of Applicant

_____
Signature of Applicant

STATE OF _____
COUNTY OF _____

The above named individual, _____, appeared before me to swear or affirm that the statements made in the Applicant's Application for a Registry Identification Card were true and correct to the best of his/her knowledge and belief this _____ day of_____, 2025.

_____
Notary Public, State at Large
My Commission Expires: