OMC-PAT001 Rev. 12-25 Commonwealth of Kentucky Cabinet for Health and Family Services Office of Medical Cannabis https://kymedcan.ky.gov KRS Chapter 218B.135(2)	TEAM KENTUCKY OFFICE OF MEDICAL CANNABIS **Authorization to Confirm Cardholder Status**	**Office Use Only:** Date Received: ____ / ____ / _____ Processed by: _____

Information and Instructions

KRS 218B.135(2) provides:

"The cabinet shall, only at the cardholder's request, confirm his or her status as a registered qualified patient, visiting qualified patient, or designated caregiver to a third party, such as [but not limited to] a landlord, employer, school, medical professional, or court."

By completing this form and sending it via email in PDF format to kymedcancards@ky.gov, you are (1) verifying and affirming that you are the cardholder identified below and all information provided in this form is true and correct to the best of your knowledge and (2) authorizing the Office of Medical Cannabis (OMC) to confirm your cardholder status to the individual or entity identified below.

Please note: the identified individual or entity will need to contact the office via email to kymedcancards@ky.gov and request confirmation of your cardholder status. The office will not contact the identified individual or entity in response to receiving this form.

Section I. *Cardholder Information*

Full Legal Name:_____ Patient License Number:_____

Email Address:_____ Phone Number: _____

Section II. *Authorized Third Party*

I authorize the OMC to confirm my cardholder status as a:

☐ Registered Qualified Patient

☐ Minor Qualified Patient *(must be submitted by the patient's custodial parent or legal guardian)*

☐ Designated Caregiver

☐ Visiting Qualified Patient

With the following Individual or Entity:

Name of Authorized Individual/Entity: _____

Address: _____

Section III. *Signature & Date*

Printed Name:_____

Signature of Cardholder (or parent or guardian, if applicable): _____

Date: ____ / ____ / _____