Medicinal Cannabis Compassionate Use Scheme

Registration Form

Part A: Registration Information – for completion by participant

Please provide your details			
Please indicate registration type	☐ new ☐ renewal ☐ updating your details or your carer details (please only include those details that have changed)		
First name		Middle name	
Last name			
Date of birth	____/____/____	Place of birth	
Usual residential address			
		Suburb	P/code
Postal address (if different from above)			
		Suburb	P/code
Home phone		Mobile phone	
Gender	☐ Male ☐ Female	Are you Aboriginal or Torres Strait Islander?	☐ Yes ☐ No

Please provide details of your nominated carer/s. You may nominate up to three carers. A carer can be nominated for no more than three registered participants (including you).
Please ask your carer if they have already been registered for three other participants before nominating them.

Carer 1	First name		Middle name	
	Last name			
	Date of birth		Place of birth	
	Residential address			
			Suburb	P/code
Carer 2	First name		Middle name	
	Last name			
	Date of birth	____/____/____	Place of birth	
	Residential address			
			Suburb	P/code
Carer 3	First name		Middle name	
	Last name			
	Date of birth	____/____/____	Place of birth	
	Residential address			
			Suburb	P/code

As well as having your certifying doctor complete Part B, please provide your certifying doctor's details (you should be able to find all of these details in the medical certification in Part B).			
First name		Middle name	
Last name			
Provider OR AHPRA number			
Practice name		Phone number	
Practice address		Suburb	P/code
In order to be registered under the Scheme you must agree to the use and disclosure of the personal and health information contained in Parts A and B of this form for the administration and enforcement of the Scheme. Do you agree?			☐ Yes ☐ No
Do you agree to the use and disclosure of the personal and health information contained in Parts A and B of this form for any future review of the Scheme?			☐ Yes ☐ No
Signature of participant		Date	

Part B: Medical Certification – for completion by medical practitioner

TERMINAL ILLNESS CERTIFICATE			
This report is made as a certificate of the opinion of a registered medical practitioner that the patient has a terminal illness for the purposes of the Medicinal Cannabis Compassionate Use Scheme. It is not an endorsement by the medical practitioner of the use of cannabis. For the purpose of the Medicinal Cannabis Compassionate Use Scheme, the definition of terminal illness is: *'an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.'*			
First name		Middle name	
Last name			
Provider OR AHPRA number		Phone number	
Practice name			
Practice address		Suburb	P/code
Patient details			
First name		Middle name	
Last name			
Date of birth	_____ /_____ /_____	Place of birth	
Usual residential address		Suburb	P/code
Postal address (if different to above)		Suburb	P/code
Relationship with patient			
Length of care relationship			
Nature of care (e.g. general practitioner, oncologist etc)			
The basis of my opinion is as follows. (Evidence relied on as a basis of certification of terminal illness.)	Details can be continued on a separate page, if necessary.		
For the purpose of certification, this medical certificate expires 2 years from date of certification. In my opinion, the patient is a person with a terminal illness as defined by the Medicinal Cannabis Compassionate Use Scheme:			
Signature of medical practitioner		Date	
Note to medical practitioners: This statement may be relied on by a member of the NSW Police Force when deciding whether to charge your patient with a criminal offence. Giving false or misleading information is a serious offence and may also amount to unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law (NSW) No. 86a*.			

Checklist

Please ensure you:

- [ ] Have Part B completed and signed by your usual treating Doctor.
- [ ] Check that your nominated carer/s has/have been nominated by no more than two other registered users and is/are willing to assist you.

Send completed Parts A and B to:

The Director
Appointments and Applications
Department of Communities and Justice
GPO Box 6
SYDNEY
NSW 2001

OR

Scan and send the completed form to Application.Services@facs.nsw.gov.au

Once your registration is processed, you will receive a record for yourself and each of your nominated carers. Please note that, in order to participate in the scheme, you and your nominated carer/s, must each carry a copy of that record and provide it to officers of the NSW Police on request.

Office use only

(To be completed by register holder and sufficient copies to be returned to participant.)

Part C: Record of Registration

Registered participant name			
Registration number			
Date of birth	_____ /_____ /_____		
Usual residential address		Suburb	P/code

Nominated carer name			
Registration number			
Date of birth	_____ /_____ /_____		
Usual residential address		Suburb	P/code

Nominated carer name			
Registration number			
Date of birth	_____ /_____ /_____		
Usual residential address		Suburb	P/code

Nominated carer name			
Registration number			
Date of birth	_____ /_____ /_____		
Usual residential address		Suburb	P/code