Mississippi Medical Cannabis Program

Industry Portal User Guide

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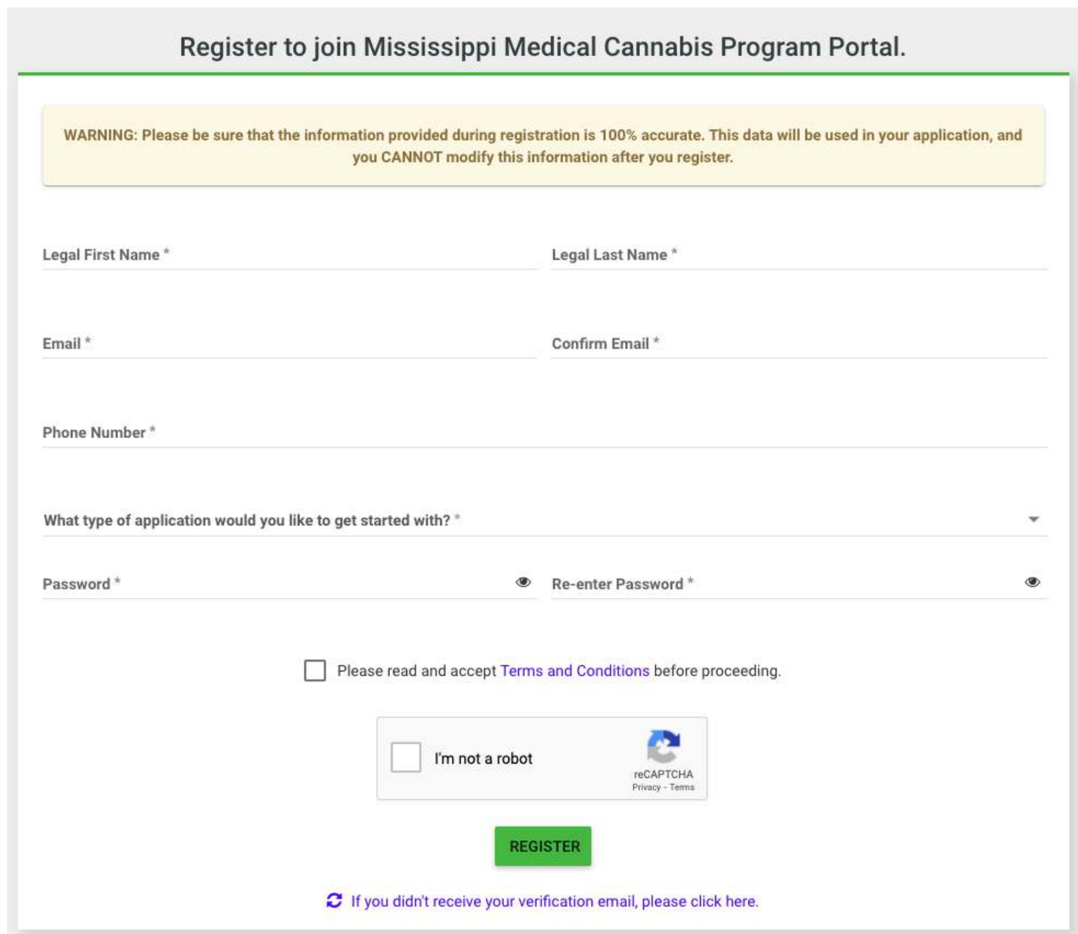
Overview

NIC Licensing Solutions (NLS) is the official web portal for the Mississippi Medical Cannabis Program. Industry stakeholders can utilize NLS to manage the application process for:

- New businesses (Cultivator Facilities, Disposal Entities, Processing Facilities, Research Facilities, Testing Facilities, Transportation Entities)
- New dispensary applications
- Practitioner registration and patient certifications
- Patient applications
- Caregiver applications
- Agent/Employee applications

Register

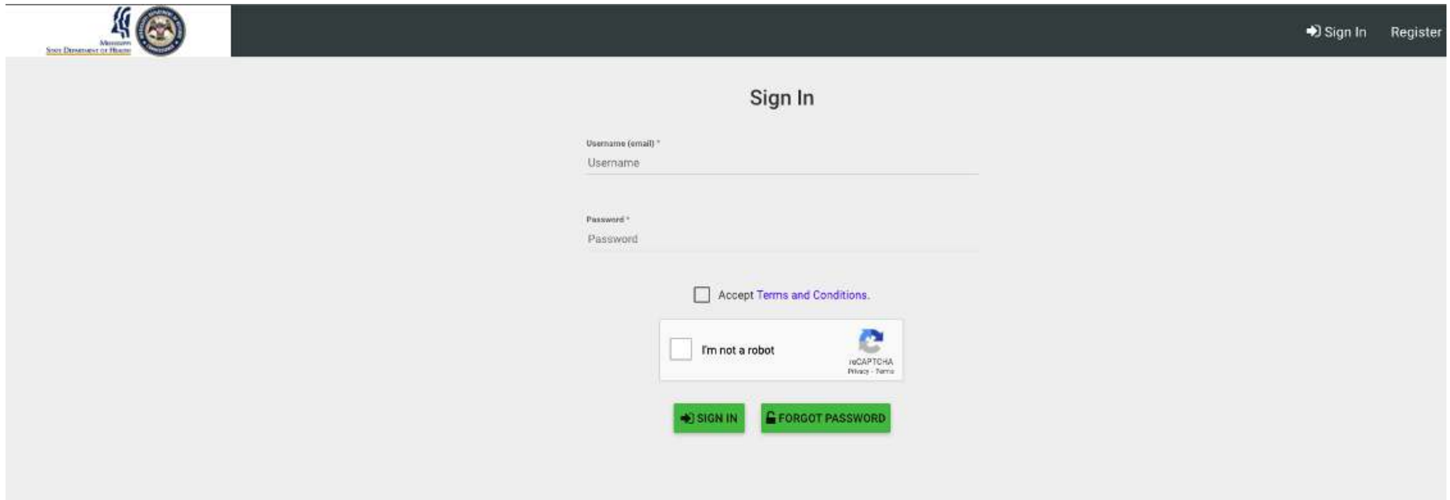
New users must first register by navigating to the Registration page: https://ms-doh-public.nls.egov.com/



Once the registration information is submitted, confirm your email address by clicking the link sent to your inbox. **You will <u>not</u> be able to log in until you verify your email address**. *(if you do not see the email link, please check all your inboxes (i.e., spam, junkmail, or quarantine).*

Log In

Once your new account email has been verified, you can log in:



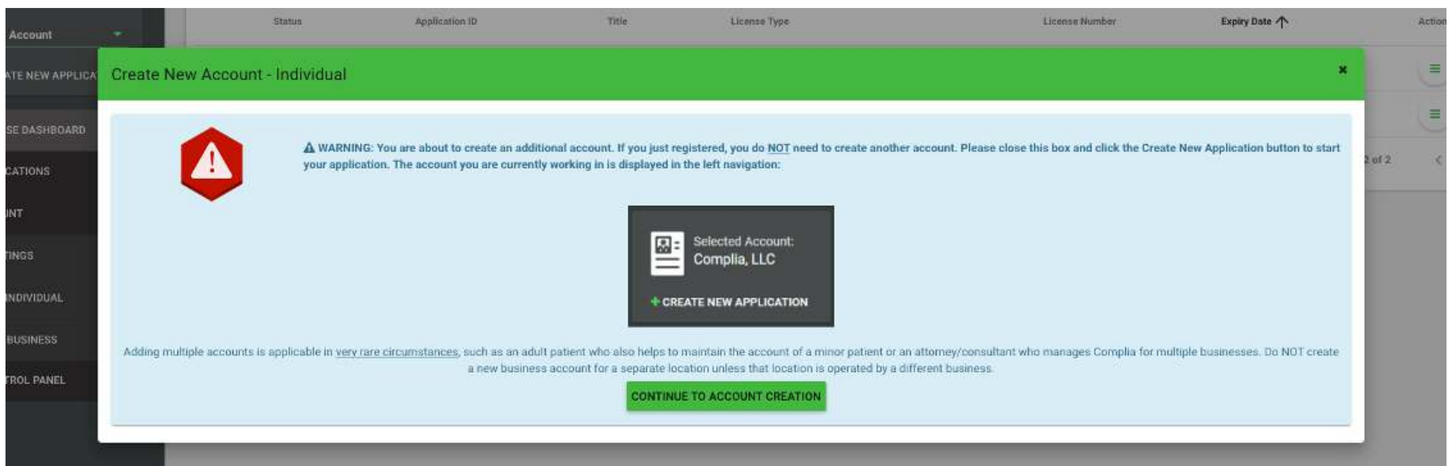
If you forget your password, click the Forgot Password button, provide your email address, and follow the instructions.

Managing Multiple Accounts

In order to keep your applications organized, separate accounts are required to submit applications for a specific individual or business. For example, if you want to apply for your patient license and a business license, you will be required to maintain those applications in two separate accounts: one for you and one for the business.

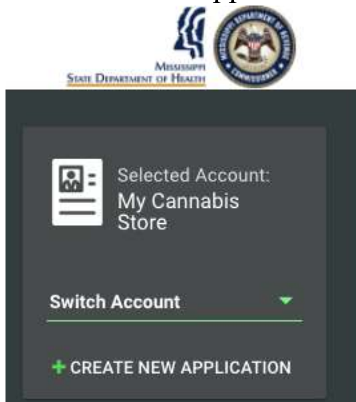
Adding multiple accounts is applicable in *very rare circumstances*, such as an adult patient who also helps to maintain the account of a minor patient or an attorney/consultant who manages the licensing for multiple businesses. Do **NOT** create a new business account for a separate location unless that location is operated by a different business.

To add a new account, expand the Account tab and select Add Individual or Add Business:



Next, click Continue to Account Creation:

The box in the upper left corner of the screen allows you to easily switch between accounts



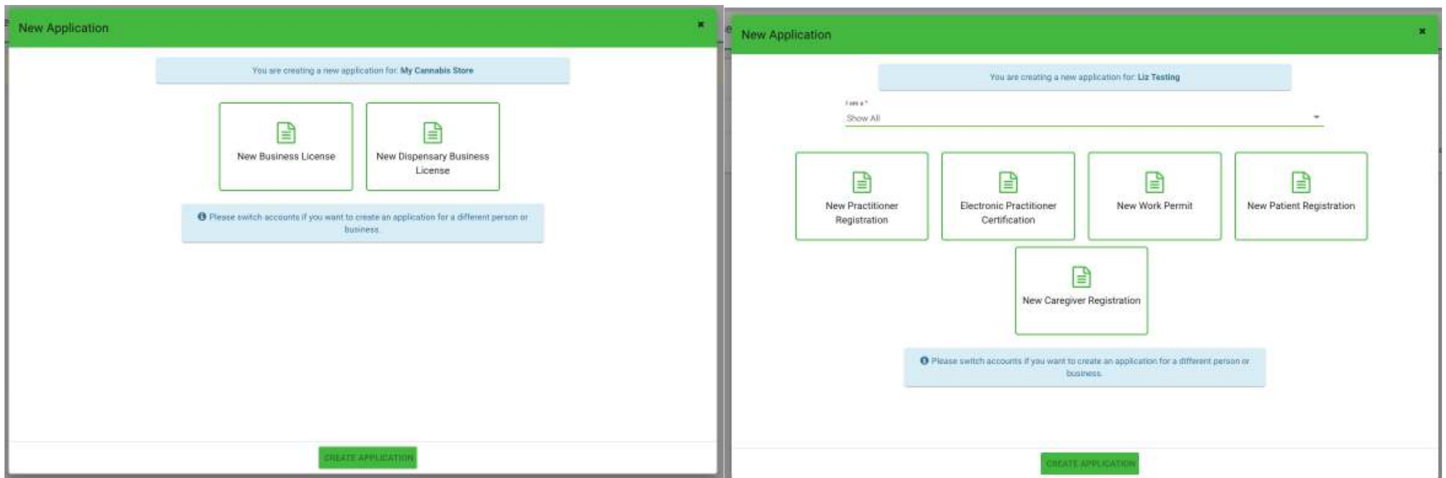
To switch between accounts, click the drop down and select the desired account.

Payment

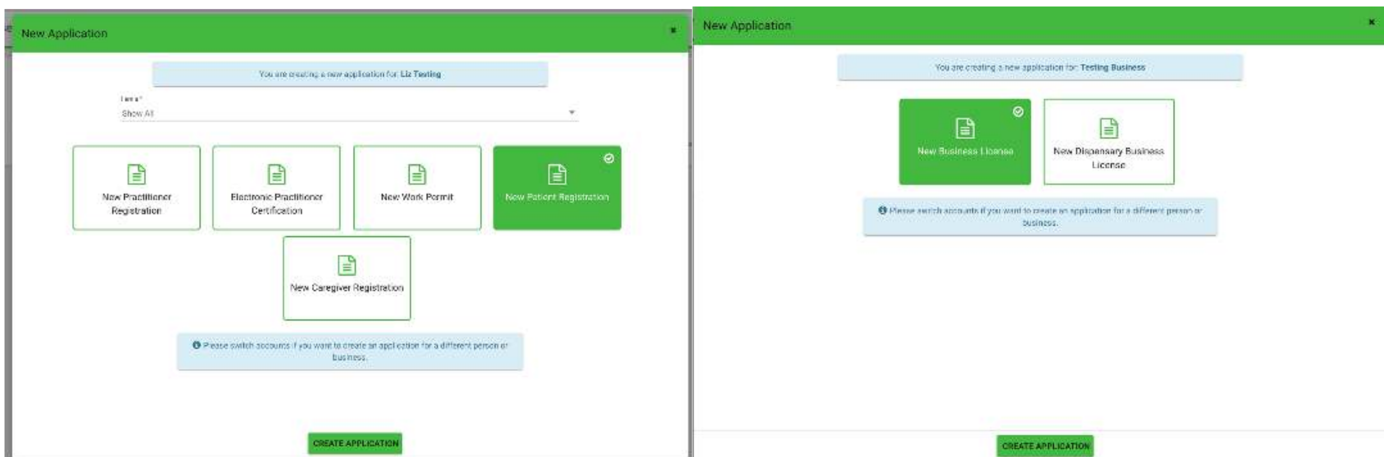
Most applications in NLS require the payment of fees as detailed by the Mississippi Cannabis rules and regulations. Please contact the Mississippi Medical Cannabis Program if you have payment related questions.

Submit a New Application

To start a new application, click the Create New Application button in the center of the screen. If you are applying as an individual, click on the “I am a…” dropdown and select the option that best applies to you. You can also select “see all” to view all application types.



Next, choose the application type you'd like to create. Be sure to verify that you are working in the proper account by verifying the information in the blue box. Click Create Application to start the application.



Once the application is created, complete all of the required information. Each application contains required data fields, question responses, and document uploads:

New Patient Registration: General Information:

Applications / New Patient Registration

Fixtures

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Legal First Name *

Middle Name

Legal Last Name *

Date of Birth *
01/01/2000

Social Security Number *
111-11-1111

Driver's License/State ID Issuing State *

Driver's License/State ID Number *

Email *
MCLicensing@msdh.ms.gov

Phone Number *

Is the Patient 18 years or older? *

Yes

No

Card Type

Card Type I am applying for: *

Are you requesting a reduced or waived fee? *

SAVE | SAVE & NEXT | CANCEL

New Patient Registration: General Information, if minor patient:

Applications / New Patient Registration

Fixtures

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Legal First Name *
This is required.

Middle Name

Legal Last Name *

Date of Birth *
01/01/2000

Social Security Number *
111-11-1111

Driver's License/State ID Issuing State *

Driver's License/State ID Number *

Email *
MCLicensing@msdh.ms.gov

Phone Number *
(___)___-____
This field is required

Is the Patient 18 years or older? *

Yes

No

Parent / Legal Guardian Information

First Name *

Middle Name

Last Name *

Date of Birth *
Date of Birth
This field is required.

Social Security Number *

Phone Number *

Email *

Card Type

Card Type I am applying for: *

Are you requesting a reduced or waived fee? *

New Patient Registration: Contact Information

Applications / New Patient Registration

Fixtures

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Permanent Residence Address

Street *
PO Box not accepted

Unit No. / Apt No.

City *

County *

State *

Zip Code *

Address Verified? * No

VERIFY ADDRESS

Mailing Address

COPY FROM RESIDENCE ADDRESS

Street *

Unit No. / Apt No.

City *

County *

State *

Zip Code *

Address Verified? * No

VERIFY ADDRESS

SAVE | SAVE & NEXT | CANCEL

New Patient Registration: Physician/Condition Information

Applications / New Patient Registration

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Recommendation

VIEW AVAILABLE CERTIFICATIONS

Condition Information

Date of Patient Examination *

Recommended Amount *

1 week Flower *

1 week Concentrate *

1 week Infused Product *

30 days Flower *

30 days Concentrate *

30 Days Infused Product *

Debilitating Medical Condition *

Certifying Provider Information

Provider First Name

Provider Last Name

Provider Type

Federal Drug Enforcement Agency Number

Provider Phone

Provider Email

Date of Provider Signature

Provider Office Address

Street

Unit No./Apt. No.

City

State

Zip Code

Address Verified? No

SAVE | SAVE & NEXT | CANCEL

New Patient Registration: Caregiver Information

Applications / New Patient Registration

Fixtures

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Do you plan to use a caregiver? *

Yes

No

Caregiver Information

Is your caregiver an individual or an entity? *

Individual

Individual Information

First Name * | Middle Name | Last Name *

Suffix | Social Security Number * | Phone *

Email * | Confirm Email * | Is your caregiver your parent? *

SAVE RECORD | ADD NEW RECORD

SAVE | SAVE & NEXT | CANCEL

Applications / New Patient Registration

Fixtures

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Do you plan to use a caregiver? *

Yes

No

Caregiver Information

Is your caregiver an individual or an entity? *

Entity

Entity Information

Facility Name * | Facility Street Name * | Facility City Name *

Facility State * | Facility Zip Code * | Facility Phone Number *

Facility Email *

SAVE RECORD | ADD NEW RECORD

SAVE | SAVE & NEXT | CANCEL

New Patient Registration: Questions and Attestations

Applications / New Patient Registration

Fixtures

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

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

Yes

No

I understand that the information contained on my identification card may be made available through a publicly accessible verification system. *

Yes

No

I attest that I will only engage in the use of marijuana that is consistent with my certifying practitioner's recommendations. *

Yes

No

I attest that I will not engage in the diversion of marijuana to any individual or entity that is not allowed to possess it pursuant to the MS Medical Cannabis Act. *

Yes

No

I understand that I must carry my program identification card, complete with photo ID, with me at all times while in the possession of marijuana for use under the MS Medical Cannabis Act. *

Yes

No

I understand that I am responsible for notifying the MS State Department of Health within 20 days of any change in my name, address, or qualifying medical condition pursuant to the MS Medical Cannabis Act. *

Yes

No

I authorize the Medical Marijuana Program to release to licensed medical cannabis dispensaries, via the state's automated system, my registration information, including: my program identification number, the term of my certification, the recommended allowable amount of medical marijuana for my use, and my dispensing history. *

Yes

No

I understand that I must notify the MS State Department of Health if I wish to change my caregiver and my caregiver must first be licensed and registered to particpate in the program. *

Yes

No

I understand that it is my responsibility to notify the MS State Department of Health within 10 days of becoming aware of my program identification card being lost or out of my possession. *

Yes

No

I understand that my program identification card may be suspended or revoked for one or more of the following: a) false information has been provided to the MS State Department of Health; b) I divert marijuana to entities or individuals; c) I use my card to obtain marijuana for another individual; and d) my practitioner certification is terminated or length of certification is decreased from the initial period of certification. *

Yes

No

I attest that the certifying practitioner explained the potential risks and benefits of the medical use of cannabis. *

Yes

No

I understand that as the legal guardian for the minor patient, I must serve as the patient's designated caregiver. *

Yes

No

I understand that it is my responsibility to control the acquisition of the medical cannabis, the dosage and frequency of the use of medical cannabis by the qualifying minor patient. *

Yes

No

Signature *

Signature Date *

__/__/____

This field is required.

SAVE | SAVE & NEXT | CANCEL

New Patient Registration: Documents

Applications / New Patient Registration

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Digital Photo * — UPLOAD

Proof of State Residency * — UPLOAD

Proof of Identity - Govt issued photo identification card * — UPLOAD

Caregiver Authorization * — UPLOAD

Parent/Legal Guardian Consent Form * — UPLOAD

Proof of Legal Guardianship * — UPLOAD

SAVE | SAVE & NEXT | CANCEL

New Patient Registration: Payment

Applications / New Patient Registration

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Payment Options *

Credit Card

ACH

SAVE | SAVE & NEXT | CANCEL

Patient Registration: Review

This is the final page, which will indicate if there are required fields missing data.

The “red X” indicates where there is a missing requirement. Click on the tab to complete the missing information or document.

Applications / New Patient Registration

GENERAL INFORMATION | CONTACT INFORMATION | CERTIFYING PRACTITIONER/ CONDITION INFORMATION | CAREGIVER INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

Please review the application for accuracy and completeness. If you have any items marked with a red X, your application will not be accepted. Please review these items to ensure accuracy
WARNING: Once your application is submitted, it cannot be modified. Please make sure your application is final and complete before submitting.

General Information

- ✖ **Legal First Name:**
- **Middle Name:**
- ✖ **Legal Last Name:**
- ✔ **Date of Birth:** 01/01/2000
- ✔ **Social Security Number:** 111111111
- ✖ **Driver's License/State ID Issuing State:**
- ✖ **Driver's License/State ID Number:**
- ✔ **Email:** MCLicensing@msdh.ms.gov
- ✖ **Phone Number:**
- ✔ **Is the Patient 18 years or older?:** No

Parent / Legal Guardian Information

- ✖ **First Name:**
- **Middle Name:**
- ✖ **Last Name:**
- ✖ **Date of Birth:**
- ✖ **Social Security Number:**
- ✖ **Phone Number:**
- ✖ **Email:**

Card Type

- ✖ **Card Type I am applying for::**
- ✖ **Are you requesting a reduced or waived fee? :**

All the license types follow the same format, where information is collected on each tab, and documents are uploaded.

New Business License:

Applications / New Business License

GENERAL INFORMATION | LICENSE INFORMATION | LOCATION INFORMATION | PRIMARY CONTACT PERSON | OWNERSHIP INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENT | REVIEW

New Dispensary License:

Applications / New Dispensary Business License

GENERAL INFORMATION | LOCATION INFORMATION | PRIMARY CONTACT INFORMATION | OWNERSHIP INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENTS | REVIEW

New Practitioner Registration:

Applications / New Practitioner Registration

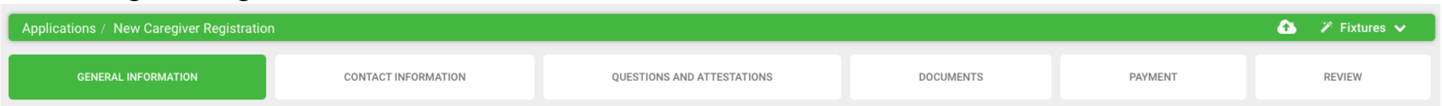
PRACTITIONER INFORMATION | CONTACT INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | REVIEW

New Agent/Work Permit:

Applications / New Work Permit

GENERAL INFORMATION | CONTACT INFORMATION | QUESTIONS AND ATTESTATIONS | DOCUMENTS | PAYMENT | REVIEW

New Caregiver Registration:



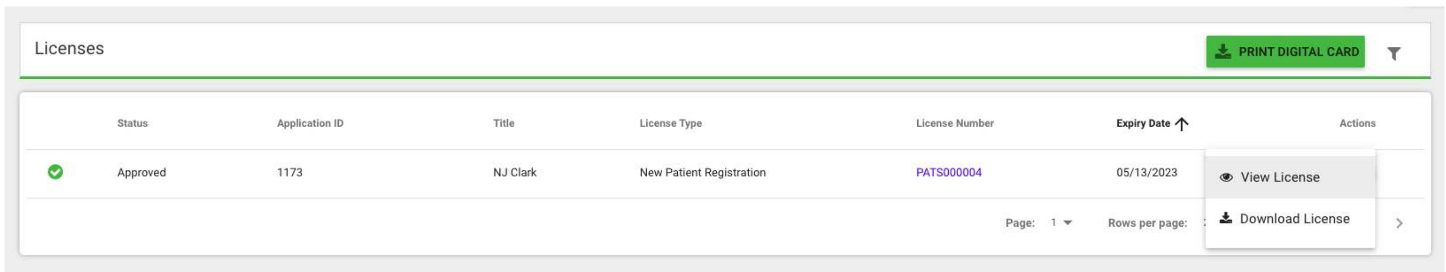
You are welcome to save the application and return to it at a later time if you need more time. Simply click save and log off.

As your application is nearing completion, navigate to the Review tab to verify all required items are completed. If you see any red X's, you'll need to go back to the applicable tab to complete the missing items.

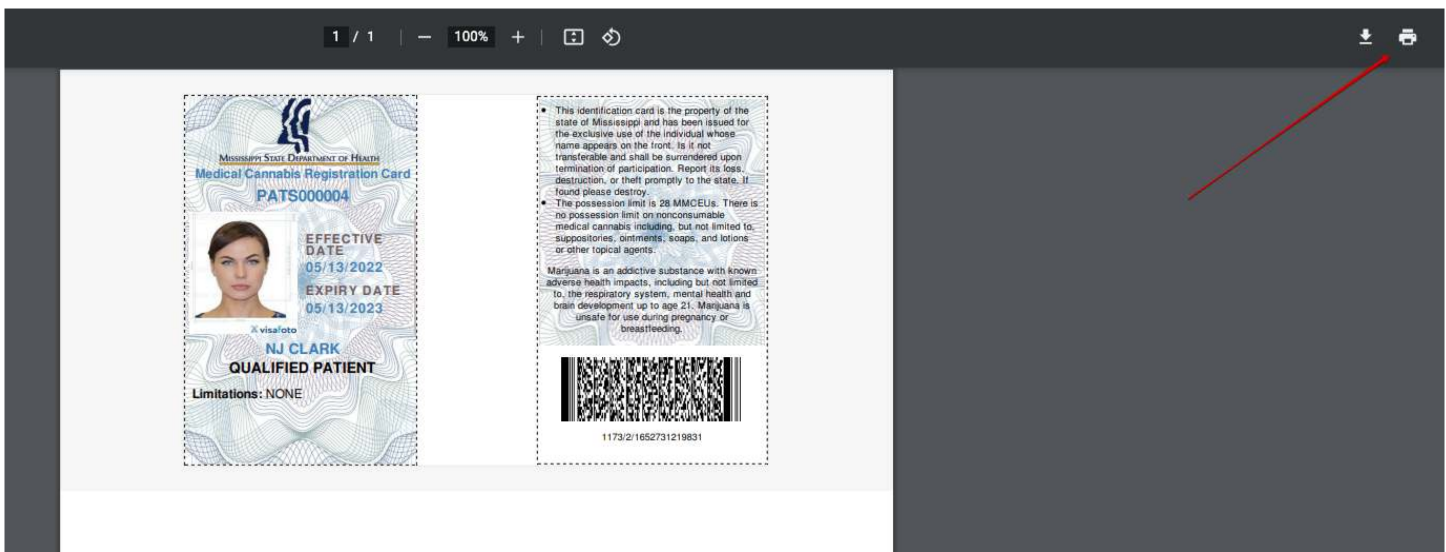
Once your application is submitted, it will be available for review by Mississippi Medical Cannabis Program personnel. Please be sure to monitor your inbox for updates as your application is reviewed. If there are issues with your application, it may be rejected. You will receive an email notification when this occurs. Rejected applications must be corrected and resubmitted through NLS.

Digital Cards and Business Licenses

In order to view and download and/or print your card, simply login to your License Dashboard. Go to the far right and click on the green "Print Digital Card" button.



Then download license, will create a pdf file. You just print like any other pdf file. It does not open in the screen, for privacy reasons. It will download a pdf file that you can save/print/open.



Support

For questions regarding application requirements, acceptable documentation, the status of your application, payments, rules, regulations, policy, or other program specific questions, please contact the Mississippi Medical Cannabis Program:

You can quickly find answers to Frequently Asked Questions (FAQS) here.

If you are a dispensary and have a policy or procedural question, please contact the Mississippi Department of Revenue (MS DOR) at

Email Address: abcpermitdepartment@dor.ms.gov
Phone Number: 601-923-7690

If you are an Individual (Patient, Practitioner, Caregiver, Agent) or a business other than dispensary and have a policy or procedural question, please contact the Mississippi Department of Health(MSDH) at

Email Address: MCLicensing@msdh.ms.gov
Phone Number: 601-206-1540

For technical support and payment questions, please contact NIC Mississippi at

Email Address: nlssupport-ms@egov.com
Phone Number: 601-351-5023