

Michigan Medical Marihuana Program
Application Instructions and Checklist
(517)373-0395 | www.michigan.gov/mmp

Instructions for applying to the Michigan Medical Marihuana Program

Instructions

1. Mail only **one** complete application and **all** required documentation (see below) in **one** envelope to:

Michigan Medical Marihuana Program
PO Box 30083
Lansing, MI 48909
2. **Make checks or money orders payable to: State of Michigan-MMMP**
3. This application is for a person who is 18 years of age or older and a resident of Michigan.
4. Please type or print legibly when completing the application.
5. The original signed Application Form and Physician Certification Form must be submitted to the MMMP. Make sure to keep a copy of the completed Application and Physician Certification Form for your records.

Checklist

- Application Form for Registry Identification Card**
 - Any use of white-out on or alterations to the Application Form will result in the denial of your application.
 - **If you are acting as either the legal guardian or Medical Durable Power of Attorney (MDPOA) for the applicant**, you must submit a copy of proof of legal guardianship or MDPOA with signatory authority with the application. The MDPOA or legal guardian must also submit a copy of their valid photo ID (see copy of valid photo ID below).
- Application Fee: \$100**
 - A patient who currently receives **full Medicaid benefits or Supplemental Security Income (SSI)** and **submits the appropriate supporting documentation** is eligible for a reduced registration fee. The reduced registration fee is \$25.00. Examples of acceptable supporting documentation are available on our website at: www.michigan.gov/mmp.
- Copy of Valid Photo ID** (Michigan Driver's license, Michigan ID card, or other acceptable form of ID)
 - The copy of the photo ID must be clear and legible.
 - **If you are designating a caregiver**, you must also submit a copy of your caregiver's valid photo ID (Michigan driver's license or Michigan ID card or other acceptable form of identification).
 - If you submit a copy of a photo ID that is not a Michigan driver's license or Michigan ID card, you must also submit a copy of your Michigan voter's registration card as proof of residency.
- Physician Certification Form**
 - A complete Physician Certification Form must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan.
 - Any use of white-out on or alterations to the Physician Certification Form will result in the denial of your application.

Michigan Medical Marihuana Program

Physician Certification Form

(517)373-0395 | www.michigan.gov/mmp

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan

Section A: Certifying Physician Information (Required)

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)
4a. Full Mailing Address		4b. Apartment/Suite/Lot #	
5. City	6. State	7. Zip Code	8. Telephone Number () -
9. Michigan Physician License Number <input type="checkbox"/> M.D. 4301 _____ <input type="checkbox"/> D.O. 5101 _____			

Section B: Patient Information (Required)

10. Legal First Name	11. Middle Initial	12a. Legal Last Name	12b. Suffix (Jr., Sr., III, etc.)
13. Date of Birth			

Section C: Patient's Debilitating Medical Condition(s) (Required)

This patient has been diagnosed with the following debilitating medical condition:
 (A minimum of one box must be checked in at least one of the following categories.)

Category A	Category B	Category C
<input type="checkbox"/> Cancer <input type="checkbox"/> Glaucoma <input type="checkbox"/> HIV Positive or AIDS <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Amyotrophic Lateral Sclerosis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Agitation of Alzheimer's Disease <input type="checkbox"/> Nail Patella	A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: <input type="checkbox"/> Cachexia or Wasting Syndrome <input type="checkbox"/> Severe and Chronic Pain <input type="checkbox"/> Severe Nausea <input type="checkbox"/> Seizures (Including but not limited to those characteristic of Epilepsy.) <input type="checkbox"/> Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of Multiple Sclerosis.)	Check and list a condition which has been approved by the Medical Marihuana Review Panel: <input type="checkbox"/> Approved medical condition: _____ _____ _____ _____

Section D: Certification, Signature and Date (Required)

By signing below, I attest that the information entered on this certification is true and accurate. I attest that I am in compliance with the Michigan Medical Marihuana Act, Administrative Rules, and all amendments. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation. Further, I attest that in my professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

Signature of Physician: X _____ Date: _____