

Department of Licensing and Regulatory Affairs
Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
www.michigan.gov/mmp

**Instructions for Making Changes to a
Medical Marihuana Registry Identification Card**

In order for the Michigan Medical Marihuana Program to process this Change Form you must submit the following information together in one envelope:

COMPLETE CHANGE FORM

- **REQUIRED: Complete Section A: PATIENT INFORMATION**
 - check the appropriate box if your address has changed.
- **REQUIRED: Complete Section B: CHANGES REGARDING PRIMARY CAREGIVER** if you are:
 - designating a new primary caregiver;
 - removing your current caregiver; or,
 - changing the address of your current caregiver.
- **REQUIRED: Complete Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS** if you designated a new primary caregiver or removed your current caregiver.
- **REQUIRED for MINORS only: Complete Section D: CHANGE IN PARENT OR LEGAL GUARDIAN WHO IS ALLOWED TO POSSESS MARIHUANA FOR MINOR PATIENT** if there has been a change in parent or legal guardianship for a minor who has been approved as a patient for the Medical Marihuana Registry.
- **REQUIRED: Section E: PATIENT'S SIGNATURE & DATE** – The Patient or, for a minor, a Parent or Legal Guardian must sign and date the Change Form.

\$10.00 CHECK OR MONEY ORDER MADE PAYABLE TO "State of Michigan—MMMP"

CLEAR COPY OF PATIENT'S CURRENT PHOTO IDENTIFICATION

COMPLETED CAREGIVER ATTESTATION AND CLEAR COPY OF CAREGIVER'S CURRENT PHOTO IDENTIFICATION (If designating a new caregiver.)

IF NAME CHANGE IS SELECTED, CLEAR COPY OF SUPPORTING DOCUMENTS (I.E., MARRIAGE LICENSE, DIVORCE DECREE, ETC)

FOR MINORS ONLY: CERTIFIED OR TRUE COPY OF NEW LEGAL GUARDIANSHIP DOCUMENTATION (If change in parent/legal guardian for minor.)

FOR MINORS Only: DECLARATION OF PERSON RESPONSIBLE FOR A MINOR (If change in parent/legal guardian for minor.)

- The Declaration can be obtained from the Medical Marihuana Registry Application for Minors application packet.

SEND ALL OF THE ABOVE APPROPRIATE DOCUMENTS TOGETHER IN ONE ENVELOPE TO:

Department of Licensing and Regulatory Affairs
Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909

If you have questions, please call the Michigan Medical Marihuana Registry Program at (517) 373-0395.

FOR OFFICIAL USE ONLY

CHANGE FORM

\$10.00 Fee Required

Check or Money Order Made Payable to State of Michigan—MMMP

For the patient’s protection, use this form to submit any changes to your current registration. **Follow the instruction page for information on how to complete this form correctly and submit the appropriate documents.**

PLEASE TYPE OR PRINT LEGIBLY

Section A: PATIENT INFORMATION: (REQUIRED) Patient’s Name Change Address Change

NAME (First, M.I., Last)			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
- -		/ /	
MAILING ADDRESS			TELEPHONE NUMBER
			()
CITY	STATE	ZIP CODE	ALTERNATE PHONE NUMBER
	MI		()

Section B: CHANGES REGARDING PRIMARY CAREGIVER: (IF APPLICABLE)

Add/Change Caregiver (Caregiver Attestation & Photo ID Required) Caregiver’s Address Change
 No Change in Caregiver Caregiver’s Name Change Remove Caregiver

NAME (First, M.I., Last)			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
- -		/ /	
MAILING ADDRESS			TELEPHONE NUMBER
			()
CITY	STATE	ZIP CODE	ALTERNATE PHONE NUMBER
	MI		()

Section C: PERSON ALLOWED TO POSSESS PATIENT’S MARIHUANA PLANTS: (REQUIRED)

NO CHANGE IN PERSON ALLOWED TO POSSESS PLANTS CHANGE TO PATIENT
 CHANGE TO NEW CAREGIVER (New caregiver’s information must be completed above.)
 CHANGE FROM PATIENT TO CURRENT CAREGIVER – Name of Current Caregiver: _____

If new Caregiver is added and no box is checked above, plant possession will default to the Applicant/Patient.

Section D: CHANGE IN PARENT OR LEGAL GUARDIAN WHO IS ALLOWED TO POSSESS MARIHUANA FOR MINOR PATIENT: (REQUIRED FOR MINORS ONLY) Parent or Legal Guardian’s Name Change
New Legal Guardianship papers and Declaration of Person Responsible for a Minor Required

NAME (First, M.I., Last)			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
- -		/ /	
MAILING ADDRESS			TELEPHONE NUMBER
			()
CITY	STATE	ZIP CODE	ALTERNATE PHONE NUMBER
	MI		()

Section E: PATIENT’S ATTESTATION, SIGNATURE, & DATE: (REQUIRED BELOW)

By signing below, I attest that the information I have entered on this change form is true and accurate:

 Signature of Patient or, for a Minor, Signature of Parent/Legal Guardian

 Date

Department of Licensing and Regulatory Affairs
Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
www.michigan.gov/mmp

Caregiver Attestation

INSTRUCTIONS: Please complete all required information in order to comply with the requirements of the Michigan Medical Marihuana Registry.

PLEASE TYPE OR PRINT LEGIBLY

DECLARATION: (REQUIRED)

I, _____, do hereby declare:

CAREGIVER'S NAME (PRINTED)

that I am willing and able to serve as the primary caregiver for:

PATIENT'S NAME (PRINTED)

I further certify that:

- I am at least 21 years of age
- I have never been convicted of a felony offense involving illegal drugs
- I understand that my caregiver registration will become null and void if I am convicted of a felony offense involving illegal drugs
- I am a caregiver for no more than 5 patients
- I have submitted a copy of my photo ID to my qualifying patient to submit with this application

PRIMARY CAREGIVER INFORMATION: (REQUIRED)

MAILING ADDRESS

TELEPHONE NUMBER

()

CITY

STATE

ZIP CODE

ALTERNATE PHONE NUMBER

MI

()

SOCIAL SECURITY NUMBER

DATE OF BIRTH

- -

/ /

OTHER NAMES USED-including maiden names for females: (REQUIRED, IF APPLICABLE)

Attach a separate page if more space required

(First, M.I., Last)

(First, M.I., Last)

(First, M.I., Last)

I understand that it is necessary to secure a criminal conviction history as part of the screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial recordkeeping organization to verify if I have been convicted of any felony offenses involving illegal drugs. The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my registration and that such misrepresentation is punishable by law.

Signature of Primary Caregiver

Date