

MINORS**ONLY**

Instructions for Applying for a Medical Marihuana Registry Identification Card FOR A **MINOR PATIENT**

In order for a minor patient (under 18 years old) to be eligible for the Michigan Medical Marihuana Registry, you must complete the minor patient application packet and submit the following together in one envelope:

APPLICATION FORM FOR REGISTRY IDENTIFICATION CARD

- REQUIRED: Complete **Section A: APPLICANT/PATIENT INFORMATION**
- REQUIRED: Complete **Section B: PARENT OR LEGAL GUARDIAN WHO IS RESPONSIBLE FOR MARIHUANA**
- REQUIRED: Complete **Section C: CERTIFYING PHYSICIANS' INFORMATION**
- REQUIRED: **Section D: ATTESTATION, SIGNATURE, & DATE**
 - The Applicant/Patient **and** the Parent or Legal Guardian must sign and date the application

PHYSICIAN CERTIFICATION FROM TWO (2) MICHIGAN LICENSED MD/DO

- You must have two physicians complete and sign the Physician Certification forms. These must be submitted with your application. DO NOT send or have medical records sent to the registry program.

DOCUMENTATION OF LEGAL GUARDIANSHIP

DECLARATION OF PERSON RESPONSIBLE FOR A MINOR APPLYING TO PARTICIPATE IN THE MICHIGAN MEDICAL MARIHUANA REGISTRY

COPY OF PATIENT AND PARENT OR LEGAL GUARDIAN'S CURRENT PHOTO IDENTIFICATION

\$100.00 APPLICATION FEE or \$25.00 APPLICATION FEE if applicant/patient is currently enrolled in Medicaid or receiving SSI or SSD and submits the appropriate supporting documents

- Check or money order only. Make payable to "State of Michigan—MMMP." Do not send cash.

COPY OF DOCUMENTATION VERIFYING RECEIPT OF BENEFITS, IF SUBMITTING \$25.00 FEE

- **Acceptable:** Current Social Security Administration document stating the patient receives disability benefits, MI Health card or other Medicaid health plan card (FULL Medicaid Only)
- **NOT ACCEPTABLE:** Medicare card, Bridge card, Bank statements, Social Security IRS Form 1099, Social Security yearly benefits statement

RETAIN A COPY OF YOUR APPLICATION FOR YOUR FILES

- These are proof that your application is in process.

SEND ALL REQUIRED DOCUMENTS TOGETHER IN ONE ENVELOPE TO THE ADDRESS AT THE TOP OF THIS FORM

- Do not send any documentation separately from the application.
- Your application will be approved or denied within 15 days of receipt by the department.
 - If determined incomplete, your application will be denied and you will receive a certified letter from the State of Michigan. You can then resubmit a copy of your application with all required documents for reconsideration without an additional fee (unless you were denied for an insufficient fee) for up to one year from receipt of your denied application.
 - If approved, your application will be processed in the date order received. The patient and the caregiver will then be issued and sent a registry ID card to the mailing address provided on the application.
- If the information provided on the application is determined to be false at any time, your registration card will become null and void.

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

FOR OFFICIAL USE ONLY

**APPLICATION FORM FOR REGISTRY
 IDENTIFICATION CARD FOR A **MINOR PATIENT****

INSTRUCTIONS: Please complete all required information to comply with the registration requirements of the Michigan Medical Marihuana Registry. Attach readable copies of photo ID(s) and your registration fee. The registration fee for this application is \$100.00 or \$25.00 if the patient is enrolled in Medicaid or receiving SSI or SSD (copies of qualifying documentation must be attached). Enclose your check or money order made payable to *State of Michigan—MMMP*. We do not accept Cash, Credit Cards, or Debit Cards.

PLEASE TYPE OR PRINT LEGIBLY

Section A: APPLICANT/PATIENT INFORMATION: (REQUIRED)

NAME (First, M.I., Last)			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
- -		/ /	
MAILING ADDRESS			PHONE NUMBER
			()
CITY	STATE	ZIP CODE	ALTERNATE PHONE NUMBER
	MI		()
Photo Identification: A clear photocopy of one of the following must be attached. Please check appropriate box:			
<input type="checkbox"/> MI Driver's License or MI ID Card # _____		<input type="checkbox"/> Other _____	

Section B: PARENT OR LEGAL GUARDIAN: (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		()
Photo Identification: A clear photocopy of one of the following must be attached. Please check appropriate box:			
<input type="checkbox"/> MI Driver's License or MI ID Card # _____		<input type="checkbox"/> Other _____	

Section C: CERTIFYING PHYSICIAN INFORMATION: (REQUIRED)

1. PHYSICIAN'S NAME	MAILING ADDRESS	TELEPHONE NUMBER
		()
2. PHYSICIAN'S NAME	MAILING ADDRESS	TELEPHONE NUMBER
		()

Section D: ATTESTATION, SIGNATURE, & DATE: (REQUIRED)

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

_____ Signature of Applicant/Patient	_____ Date
_____ Signature of Parent or Legal Guardian	_____ Date

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

Physician Certification #1 for a MINOR PATIENT

INSTRUCTIONS: THIS CERTIFICATION IS TO BE COMPLETED IN ITS ENTIRETY BY THE PHYSICIAN. Please complete all of the information required on this form. Sign the form and keep a copy in the patient's medical record. The patient must submit this certification along with his/her application for a Michigan Medical Marihuana Registry identification card. This does not constitute a prescription for marihuana. You may contact the Michigan Medical Marihuana Program at (517) 373-0395 if you have any questions or concerns. PLEASE TYPE OR PRINT LEGIBLY

PHYSICIAN INFORMATION: (REQUIRED)

Name (First, M.I., Last) SELECT ONE: [] M.D. [] D.O.

MAILING ADDRESS REQUIRED: MICHIGAN PHYSICIAN LICENSE NUMBER

CITY STATE ZIP CODE TELEPHONE NUMBER ()

PHYSICIAN'S STATEMENT: (REQUIRED)

I certify that Patient's Name (REQUIRED) Date of Birth has been diagnosed with

the following debilitating medical condition (check appropriate boxes):

- [] Cancer
[] Glaucoma
[] HIV or AIDS Positive
[] Hepatitis C
[] Amyotrophic Lateral Sclerosis
[] Crohn's Disease
[] Agitation of Alzheimer's Disease
[] Nail Patella

- OR a medical condition or treatment that produces, for this patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of medical marihuana.
[] Cachexia or Wasting Syndrome
[] Severe and Chronic Pain
[] Severe Nausea
[] Seizures (Including but not limited to those characteristic of Epilepsy.)
[] Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of Multiple Sclerosis.)

Physician's Comments: (Please Type or Print Legibly)

Horizontal lines for physician comments.

CERTIFICATION, SIGNATURE, & DATE: (REQUIRED)

I hereby certify that I am a physician licensed to practice medicine in Michigan. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated above. The medical use of marihuana is likely to be palliative or provide therapeutic benefits for the symptoms or effects of applicant's condition. This is not a prescription for the use of medical marihuana. Additionally, if the patient ceases to suffer from the above identified debilitating condition, I hereby certify I will notify the department in writing.

Physician's Signature Date

Provide the name and telephone number of contact person at the physician's office to verify validity of certification:

(Name - Please Print) (Telephone Number)

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

Physician Certification #2 for a MINOR PATIENT

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PHYSICIAN INFORMATION: (REQUIRED)

Name (First, M.I., Last) SELECT ONE: [] M.D. [] D.O.

MAILING ADDRESS REQUIRED: MICHIGAN PHYSICIAN LICENSE NUMBER

CITY STATE ZIP CODE TELEPHONE NUMBER ()

PHYSICIAN'S STATEMENT: (REQUIRED)

I certify that Patient's Name (REQUIRED) Date of Birth has been diagnosed with

the following debilitating medical condition (check appropriate boxes):

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[] Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of Multiple Sclerosis.)

Physician's Comments: (Please Type or Print Legibly)

Physician's Signature Date

CERTIFICATION, SIGNATURE, & DATE: (REQUIRED)

I hereby certify that I am a physician licensed to practice medicine in Michigan. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated above. The medical use of marihuana is likely to be palliative or provide therapeutic benefits for the symptoms or effects of applicant's condition. This is not a prescription for the use of medical marihuana. Additionally, if the patient ceases to suffer from the above identified debilitating condition, I hereby certify I will notify the department in writing.

Physician's Signature Date

Provide the name and telephone number of contact person at the physician's office to verify validity of certification:

(Name - Please Print) (Telephone Number)

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Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
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Declaration of Person Responsible for a **MINOR PATIENT Applying to Participate in the Michigan Medical Marihuana Registry (Parent or Legal Guardian)**

INSTRUCTIONS: Please complete all required information in order to comply with the requirements of the Michigan Medical Marihuana Registry. This form is required in addition to the patient application form if the patient is under 18 years of age.

PLEASE TYPE OR PRINT LEGIBLY

DECLARATION BY PARENT OR LEGAL GUARDIAN: (REQUIRED)

I, _____, do hereby declare:

That I am the Parent/Legal Guardian (**circle one**) with responsibility for health care decisions for:

Applicant's Name

- The applicant's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marihuana.
- I consent to the use of marihuana by the applicant for medical purposes.
- I agree to serve as the applicant's designated primary caregiver.
- I agree to control the acquisition of marihuana and the dosage and frequency of use by the applicant.
- I have provided statements of certification regarding the patient's status from two (2) licensed physicians.

PARENT OR LEGAL GUARDIAN INFORMATION: (REQUIRED)

ADDRESS			TELEPHONE NUMBER ()
CITY	STATE MI	ZIP CODE	ALTERNATE PHONE NUMBER ()

RELATIONSHIP TO APPLICANT

SOCIAL SECURITY NUMBER OF PARENT OR LEGAL GUARDIAN

- -

Parent's or Legal Guardian's Signature

Date