

RENEWAL**APPLICATION**

Instructions for Applying for a **RENEWAL** Medical Marihuana Registry Identification Card

To renew your Michigan Medical Marihuana Registry ID card, you must complete the renewal application packet and submit the following together in one envelope:

RENEWAL APPLICATION FORM FOR REGISTRY IDENTIFICATION CARD

- **REQUIRED: Complete Section A: APPLICANT/PATIENT INFORMATION**
 - Required if Patient's Name Change is selected, clear copy of supporting documents (i.e., Marriage License, Divorce Decree, etc.)
- **IF APPLICABLE: Complete Section B: PRIMARY CAREGIVER**
 - Required if you are designating a new caregiver or continuing with your current caregiver
 - "Primary caregiver" means a person who is at least 21 years old and who has agreed to assist with a patient's medical use of marihuana and who has never been convicted of a felony involving illegal drugs
 - Required if Caregiver's Name Change is selected, clear copy of supporting documents (i.e., Marriage License, Divorce Decree, etc.)
- **REQUIRED: Complete Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS**
- **REQUIRED: Complete Section D: CERTIFYING PHYSICIAN INFORMATION**
- **REQUIRED: Section E: ATTESTATION, SIGNATURE, & DATE**
 - The Patient must sign and date the application

COPY OF PATIENT'S PHOTO IDENTIFICATION

NEW PHYSICIAN CERTIFICATION FROM MICHIGAN LICENSED MD/DO

- Your physician must complete and sign the Physician Certification form. This must be submitted with your renewal application. **DO NOT** send or have medical records sent to the registry program.

NEW CAREGIVER ATTESTATION and COPY OF CAREGIVER'S PHOTO IDENTIFICATION

- Required if you are designating a caregiver in Section B

\$100.00 RENEWAL APPLICATION FEE or \$25.00 APPLICATION FEE if 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, VA disability, Retirement benefits

RETAIN A COPY OF YOUR RENEWAL APPLICATION FOR YOUR FILES

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 renewal application.
- Your renewal application will be approved or denied within 15 days of receipt by the department.
 - If determined incomplete, your renewal application will be denied and you will receive a certified letter from the State of Michigan. You can then resubmit a copy of your renewal 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 renewal application.
 - If approved, your renewal application will be processed in the date order received. The patient, and if applicable, the caregiver, will then be issued and sent a registry ID card to the mailing address provided on your renewal application.
- If the information provided on the renewal 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

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

**RENEWAL APPLICATION FORM FOR
 REGISTRY IDENTIFICATION CARD**

INSTRUCTIONS: Please complete all required information to comply with the renewal 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) Patient's Name Change Address Change

NAME (First, M.I., Last)			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
SOCIAL SECURITY NUMBER	PATIENT REGISTRY ID NUMBER	DATE OF BIRTH	
- -	P	/ /	
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:
 MI Driver's License or MI ID Card # _____ Other _____

Section B: PRIMARY CAREGIVER: (IF APPLICABLE) Add/Change Caregiver Address Change
 Caregiver's Name Change

NAME (First, M.I., Last)			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
SOCIAL SECURITY NUMBER	CAREGIVER REGISTRY ID NUMBER	DATE OF BIRTH	
- -	C	/ /	

Only list the caregiver number if the caregiver is **already registered** with this patient.

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:
 MI Driver's License or MI ID Card # _____ Other _____

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

SELECT ONE: APPLICANT/PATIENT **OR** PRIMARY CAREGIVER (Caregiver Attestation & photo ID Required)

If neither or both boxes are checked, plant possession will default to the Applicant/Patient.

Section D: CERTIFYING PHYSICIAN INFORMATION: (REQUIRED)

PHYSICIAN'S NAME	MAILING ADDRESS	TELEPHONE NUMBER
		()

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

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

 Signature of Applicant/Patient

 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: The person wishing to be a qualifying patient's primary caregiver must complete this Attestation in its entirety 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 the below statements are true:

- 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 qualifying patients
- I have submitted a copy of my photo ID to my qualifying patient to submit with this renewal application

PRIMARY CAREGIVER INFORMATION: (REQUIRED)

MAILING ADDRESS

TELEPHONE NUMBER

()

CITY

STATE

ZIP CODE

ALTERNATE PHONE NUMBER

MI

()

SOCIAL SECURITY NUMBER

DATE OF BIRTH

-

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**OTHER NAMES USED BY PRIMARY CAREGIVER -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