

****APPLICATION FORM****
for Registry Identification Card

• For Applicants/Patients 18 years of age or older

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

• Please call our office if you have any questions

• Submit ALL documents in ONE envelope • We recommend the applicant/patient submit the application packet • Type or print legibly

NEW: I have **never** applied before or my registry ID card is **expired** **RENEWAL:** My current registry ID card is **not** expired

For Renewals: Check any Changes: Patient Address Change Caregiver Address Change Plant Possession
 Patient Adding or Changing to New Caregiver (List the new caregiver's information in Section B)
 Patient Name Change Caregiver Name Change (Documents required for name changes; see question #2 on page 2)

Section A: APPLICANT/PATIENT INFORMATION: (REQUIRED)

For Renewals: Current Card Registry ID Card Number: **P** _____ Male Female

Legal Name (First): _____ (MI): _____ (Last): _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ (if applicable)
Apt/Lot # _____

City: _____ Zip: _____ Phone Number (with area code): _____

Alternate Phone Number (with area code): _____

****A patient who is 18 years of age or older is not required to designate a caregiver****

► To add or change to a new caregiver or retain your current caregiver, you **must** complete Section B and refer to questions #8-9 on page 2.

► Leave Section B blank **ONLY** if you are **NOT** designating a caregiver.

Section B: PRIMARY CAREGIVER INFORMATION: (IF APPLICABLE)

For Renewals: If already registered to this patient, Current Registry ID Card Number: **C** _____ Male Female

Legal Name (First): _____ (MI): _____ (Last): _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ (if applicable)
Apt/Lot # _____

City: _____ Zip: _____ Phone Number (with area code): _____

Alternate Phone Number (with area code): _____

Plant possession will default to the Applicant/Patient if neither or both boxes are checked in Section C.

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

SELECT ONLY ONE: APPLICANT/PATIENT <----- **OR** -----> PRIMARY CAREGIVER

Michigan Medical Marihuana Registry APPLICATION FORM

To ensure this application is complete, the Applicant/Patient must answer **YES** to all of the applicable questions below:

1. Did you, the applicant/patient, answer all of the fields correctly and legibly in **Section A**?..... YES
2. **For renewals**, is a copy of documentation provided for a name change? (if applicable)
(i.e., marriage/divorce decree, legal name change document, valid MI driver license or Michigan ID, etc)..... YES
3. Are all of the fields for the caregiver answered correctly and legibly in **Section B** (if you, the patient, designated a caregiver)?.....(if applicable)
..... YES
4. Is only one box checked in **Section C** for person who is allowed to possess the patient's Marihuana plants?..... YES
5. Did you, the applicant/patient, sign and date this application in **Section D** below?.....(if #5 is NO, #6 must be YES)
..... YES NO
6. **OR**, is a copy of a **Durable Power of Attorney for Health Care** or legal guardianship with signatory authority provided, if the applicant/patient is unable to sign this application?.....(if #6 is NO, #5 must be YES)
..... YES NO
7. Is a valid, clear copy (front and back) of the applicant/patient's Michigan driver license or Michigan ID provided **OR** your **photo ID and Michigan voter registration** provided?..... YES
8. Is a valid, clear copy (front and back) of the caregiver's Michigan driver license or Michigan ID provided **OR** his/her **photo ID and Michigan voter registration** provided (if you, the applicant/patient, designated a caregiver in Section B)?.....(if applicable)
..... YES
9. Is a copy of the **Caregiver Attestation**, correctly and legibly completed by the caregiver, provided (if you, the applicant/patient, designated a caregiver in Section B)?.....(if applicable)
..... YES
10. Is the **Physician Certification** provided?..... YES
11. Is the \$100.00 Registration Fee included, payable to State of Michigan-MMMP?.....(if #11 is NO, #12 must be YES)
..... YES NO
Enter the \$100.00 Check or Money Order # _____
12. **OR**, if you are eligible for the reduced fee, is the \$25.00 Registration Fee included, payable to State of Michigan-MMMP? (Additional documents **required**-See #13).....(if #12 is NO, #11 must be YES)
..... YES NO
Enter the \$25.00 Check or Money Order # _____ (if applicable)
13. Is the acceptable supporting documentation for the reduced fee included?..... YES
Examples of acceptable supporting documentation for the reduced fee are available at www.michigan.gov/mmp.
14. Check the program you, the applicant/patient, are currently enrolled in which qualifies you for the reduced fee:
 Full Medicaid Supplemental Security Income (SSI)
15. Make a copy for your records and mail only one complete application, the check or money order, and all required documentation **in one envelope** to: **Michigan Medical Marihuana Registry Program · PO Box 30083 · Lansing, MI 48909**

Section D: APPLICANT/PATIENT 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: **X** _____ Date: _____

WHAT TO EXPECT AFTER YOU SUBMIT YOUR APPLICATION:

1. When your application is received by our office it will be approved or denied within 15 business days.
2. If this application is denied, the patient will receive a certified letter of explanation. You can then resubmit a copy of the application, with all required documents, for reconsideration up to 2 years from the date the fee is received.
3. If this application is approved, it will be processed in the date order received. The patient, and caregiver if designated, will be issued and sent a registry ID card to the mailing address provided on this application.
4. **If you have not received a denial letter, an approval letter, or some form of notification within six (6) weeks from the date the MMP receives your valid application, please contact our office at 517-373-0395 and select option #3. Please allow a full 6 weeks.**
5. After submitting this application, any changes to your record (address, caregiver, name, etc.), prior to your registry ID card's expiration, should be submitted on a Change Form with the required fee. We recommend not submitting a Change Form within 60 days of submitting your renewal application.

Michigan Medical Marihuana Registry Caregiver Attestation

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

TYPE OR PRINT LEGIBLY

The person the applicant/patient is designating to be their primary caregiver must complete this form in its entirety. This form must be submitted by the applicant/patient along with his/her application or change form.

If the applicant/patient has never had a Michigan registry ID card or if the patient's card will expire within the next 60 days, they should submit this attestation with an application form. If the applicant/patient has recently submitted their application or renewal application, they should submit this attestation with a change form. If you have questions on which form to use, please contact the MMP at 517-373-0395.

DECLARATION: (REQUIRED)

I, _____, do hereby declare each of the
(Print CAREGIVER'S NAME above)

below statements are true and accurate:

The designated caregiver must initial each line below:

- I am at least 21 years of age at the time I am signing this Attestation.
- I acknowledge at the time I am signing this Attestation I am not a caregiver for more than 5 qualifying patients.
- I will not possess more than 2.5 ounces of usable marihuana and 12 marihuana plants for this qualifying patient if the applicant/patient named below designates me to possess his/her marihuana plants on the application or change form submitted with this Attestation (see Section C of the application or change form).
- I have provided a front and back copy of my Michigan driver license or Michigan state ID (OR a front and back copy of my photo ID and Michigan voter registration) to this applicant/patient to submit his/her application or change form.
- I have never been convicted of ANY felony offense involving illegal drugs.
- I have not been convicted of ANY felony offense within the past 10 years. (Attestations received on or after April 1, 2013)
- I have never been convicted of ANY felony that is an assaultive crime as defined in Section 9a of Chapter X of the code of criminal procedure, 1927 PA 175, MCL 770.9a. (Attestations received on or after April 1, 2013)
Some examples are listed below (this is not an all-inclusive list). If you have questions, please seek legal counsel.

Threats/assault against employee of Family Independence Agency	Stalking or aggravated stalking	Felonious Assault
Assault with intent to do great bodily harm less than murder; assault by strangulation or suffocation	Assault with intent to commit felony not otherwise punished	Assault with intent to maim
Leading, taking, carrying away, decoying, or enticing away child under 14	Conduct proscribed under MCL 750.81 to 750.89 as felony; intent [to commit conduct against a pregnant individual in order to cause or which leads to a miscarriage or stillbirth, or other harm to the embryo or fetus]	Attempted murder, 1 st or 2 nd degree murder
Kidnapping/Prisoner taking person as hostage	Felonious Use of Explosives (MCL750.200-MCL750.212a)	Assault with intent to commit murder
Assault with intent to rob and steal; armed or unarmed	Terrorism: Violation of the Michigan Anti-Terrorism Act (MCL750.543a-750.543z)	Assault with intent to commit CSC or CSC 1 st , 2 nd , 3 rd , or 4 th degree
Use or possession of dangerous weapon		Carjacking
		Manslaughter
		Mayhem
		Larceny of money or other property

- I understand that my caregiver registration will become null and void if I am convicted of a felony offense.
- I am willing, able, and eligible to serve as the primary caregiver for:

Print Applicant/Patient's Name: _____

Michigan Medical Marihuana Registry Caregiver Attestation

All fields below must be completed.

PRIMARY CAREGIVER INFORMATION: (REQUIRED)

Legal Name (First): _____ (MI): _____ (Last): _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ (if applicable)
Apt/Lot # _____

City: _____ Zip: _____ Phone Number (with area code): _____

Alternate Phone Number (with area code): _____

**List any maiden names or nick names used now or in the past that you, the caregiver (male or female) have used.
Attach a separate page if more space is required.**

OTHER NAMES USED BY CAREGIVER : (IF APPLICABLE)

Legal Name (First): _____ (MI): _____ (Last): _____

Legal Name (First): _____ (MI): _____ (Last): _____

Legal Name (First): _____ (MI): _____ (Last): _____

CAREGIVER DECLARATION: (REQUIRED)

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 of the felony offenses that would make me ineligible to be a caregiver. I have not withheld information that might affect the decision to be made on this application. In signing this attestation, I am aware that a false statement or dishonest answer may be grounds for denial or revocation of my registration and that such misrepresentation is punishable by law. I declare that I am willing and able to serve as the primary caregiver for the below signed patient.

Signature of Caregiver: **X** _____ Date: _____

APPLICANT/PATIENT DECLARATION:

I declare that I am designating the above signed individual to be my caregiver. I have included this caregiver's name and information in Section B: Primary Caregiver on the enclosed application or change form. I have included a copy of this caregiver's Michigan driver license or Michigan state ID (OR his/her photo ID and Michigan voter registration) and this completed Caregiver Attestation.

Signature of Applicant/Patient: **X** _____ Date: _____

To ensure this attestation is complete, the caregiver must answer **YES** to all of the applicable questions below:

1. On page 1, did you, the caregiver, print your name in the designated area at the top?..... YES
2. On page 1, did you, the caregiver, initial each statement verifying your eligibility to be a caregiver?..... YES
3. On page 1, did you, the caregiver, print the patient's name in the designated area at the bottom?..... YES
4. On page 2, did you, the caregiver, complete all fields correctly and legibly?..... YES
(if applicable)
5. On page 2, did you, the caregiver, enter all other previous and current names used?..... YES
6. On page 2, did the caregiver and patient sign in the appropriate designated areas?..... YES
7. Provide this Attestation to the applicant/patient to submit to the MMP with the appropriate application or change form

Michigan Medical Marihuana Registry Physician Certification

- Please encourage patients to submit their application packets as soon as possible after you sign this certification.

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

****This certification does not constitute a prescription for marihuana.****

CERTIFYING PHYSICIAN INFORMATION: (REQUIRED) **TYPE OR PRINT LEGIBLY**

Physician Name (First): _____ (MI): _____ (Last): _____

Full Address: _____

Phone Number (with area code): _____

Michigan Physician

OR

License Number: M.D. 4301 _____ D.O. 5101 _____

DECLARATION:

The physician must initial each line below:

I do hereby declare I am in compliance with the Michigan Medical Marihuana Act, Section 3a, which includes all of the following:

___ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))

___ I have created and will maintain records of this patient's condition in accord with medically accepted standards. (MCL333.26423(a)(2))

___ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))

___ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition. (MCL333.26423(a)(4))

For Minor Patients ONLY:

___ I have explained the potential risks and benefits of the medical use of marihuana to the qualifying patient and to his or her parent or legal guardian. (MCL333.26426(b)(1))

PATIENT INFORMATION: (REQUIRED) **TYPE OR PRINT LEGIBLY**

Male Female Date of Birth: _____

Legal Name (First): _____ (MI): _____ (Last): _____

Date of this patient's in-person medical evaluation relating to this certification: _____

I certify that the above named patient has been diagnosed with the following debilitating medical condition (check appropriate box(es)):
A checkbox must be selected below and/or on page 2 for this patient.

Cancer

Amyotrophic Lateral Sclerosis

Glaucoma

Crohn's Disease

HIV or AIDS Positive

Agitation of Alzheimer's Disease

Hepatitis C

Nail Patella

Other condition not listed, which **has been approved** as a qualifying condition pursuant to the

Medical Marihuana Review Panel (MCL 333.26425a) _____

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

Michigan Medical Marihuana Registry Physician Certification

I certify that the named patient on page 1 of this certification has been diagnosed with a medical condition or treatment that produces, for this patient, one or more of the following and which, in this physician's professional opinion, may be alleviated by the medical use of marihuana (check appropriate box(es)):

Legibly print the medical condition or treatment

- 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 (if applicable): (Please Type or Print Legibly)

CERTIFICATION, SIGNATURE, & DATE: (REQUIRED)

I hereby certify that I am a physician licensed to practice in Michigan. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated on this form. The medical use of marihuana is likely to provide palliative or therapeutic benefits for the symptoms or effects of the patient'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.

Signature of Physician: X _____ Date: _____

(Fully licensed Michigan MD or DO only)

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

Name: _____ Phone Number (with area code): _____

To ensure this certification is complete, the physician must answer **YES** to all of the applicable questions below:

1. On page 1, is the physician information complete with all fields correctly and legibly typed or printed in the Certifying Physician Information section?..... YES
2. On page 1, did you, the physician, initial each statement verifying compliance with the MMMA?..... YES
3. On page 1, is the patient information complete with all fields correctly and legibly typed or printed in the Patient Information section?..... YES
4. On page 1, did you, the physician, identify the qualifying debilitating medical condition(s) for this patient?..... YES (Either #4 or #5 must be checked YES)
5. On page 2, did you, the physician, identify the qualifying diagnosis AND state the medical condition(s) or treatment for this patient?..... YES (Either #4 or #5 must be checked YES)
6. On page 2, did you, the physician, sign the Certification in the appropriate designated area?..... YES
7. Did you, the physician, give this Certification to the patient to submit with their application?..... YES
8. Did you retain a copy of this Certification for this patient's records?..... YES