CANNABIS REGULATORY AGENCY

www.michigan.gov/mmp

(517) 284-8599

For Official Use Only
No Fee

Remove Patient Amendment

This form is for active registered **Caregivers** who are removing one or more current Patient(s).

Instructions

1. Complete the entire form.
2. **Required**: Include copy of caregiver's valid state-issued driver license, OR personal identification card.
3. List all Patient(s) you would like to remove in **Section B: Remove Patient(s).**
4. This form must be signed and dated within 6 months of being received by the MMMP.
5. Keep a copy of all documents for your records.
6. Mail completed form and all required documents in one envelope to:

Michigan Medical Marijuana Program
PO Box 30083
Lansing, MI 48909

Section A: Caregiver Information

Legal First Name	Middle Initial	Legal Last Name

Date of Birth (MM/DD/YY)	Telephone Number *(optional)*

Current Mailing Address including Apartment/Suite/Lot #

City	State	Zip Code

Section B: Remove Patient(s)

1.

2.

3.

4.

5.

Section C: Caregiver Signature & Date

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2018, MCL 333.26421 *et seq.*) and associated administrative rules. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution.

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