CANNABIS REGULATORY AGENCY

MINOR Patient Only

This packet contains the MINOR Application/Renewal form for a Michigan Medical Marijuana Program (MMMP) Patient Registry Card. Please read the Michigan Medical Marihuana Act and Administrative Rules for the Michigan Medical Marijuana Program so you are familiar with all requirements. They can be found at www.michigan.gov/mmp.

Instructions to Apply or Renew by paper via mail

- Use the most up to date application found at www.michigan.gov/mmp
- This application is for a person who is under 18 years of age and a resident of Michigan.
- If there has been a name change for the patient, please include all documents of legal name change leading up to current legal name of the patient (i.e., legal name change document, adoption paperwork, etc.)
- If the patient has a Michigan driver license OR personal ID issued by Secretary of State it may be included with the application, it is not required.
- Two Physician Certification Forms must be completed and signed by two separate physicians. Each physician must be a Medical Doctor OR Doctor of Osteopathic Medicine and Surgery who holds a current license to practice in the state of Michigan.
- The application, declaration page, and both physician certifications must be signed & dated within 6 months from the date they are received by the MMMP.
- A Parent or Legal Guardian, 21 years of age or older must serve as the designated caregiver. They must provide Proof of Michigan Residency, which can be a valid clear copy of Michigan driver license OR personal ID issued by Secretary of State OR a signed voter registration. Only the front is required.
  - If the caregiver submits a voter registration, they shall also submit a copy of a government-issued document that includes the caregiver's name and date of birth for verification purposes.
- Proof of parentage or legal guardianship document is required (i.e., birth certificate, court order, etc.) If there has been a name change for the caregiver, please include all documents of legal name change leading up to current legal name of the caregiver (i.e., marriage license, divorce decree, etc.)
- Any use of white-out or changes to the application form or physician certification forms will result in the denial of application.
- Keep a copy of all documents for your records.
- Mail only one completed application and all required items in one envelope to:

Michigan Medical Marijuana Program
PO Box 30083
Lansing, MI 48909

Checklist of completed items to put in envelope:

- ☐ 1. MINOR Application Form for Registry Identification Card.
- ☐ 2. Declaration of Person Responsible for MINOR Patient.
- ☐ 3. Two Physician Certification Forms.
- ☐ 4. Proof of Michigan Residency for the designated caregiver, only the front is required.
- ☐ 5. Proof of parentage or legal guardianship document. Any additional document(s) to reflect legal name change(s), if applicable.
- ☐ 6. Application fee of $40. This can be a check or money order payable to: **State of Michigan-MMMP**

CANNABIS REGULATORY AGENCY

For Official Use Only
$40 Fee Required

Michigan Medical Marijuana Program
PO Box 30083
Lansing, MI 48909

www.michigan.gov/mmp
(517) 284-6400

Application Form for Registry Identification Card
MINOR Applicants Only

See page 1 for instructions.

Section A: Minor Patient Information

Legal First Name	Middle Initial	Legal Last Name
Date of Birth (MM/DD/YY)		
Current Mailing Address including Apartment/Suite/Lot #		
City	State **MI**	Zip Code

The parent or legal guardian listed in Section C must serve as the patient's caregiver and possess the minor patient's medical marijuana plants.

Section B: Parent or Legal Guardian 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 **MI**	Zip Code
Other Names Used by Caregiver (maiden names, nicknames, etc.)		

Section C: Parent/Legal Guardian 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 2008, MCL 333.26421 *et seq.*) and associated administrative rules. I attest that I am at least 21 years old, have no felony convictions that disqualify me from serving as a primary caregiver, and authorize the department to use the information provided in this application to perform a criminal background check. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the release of the above named patient's protected health information, which includes the information contained in the forms completed by the certifying physicians, to the Michigan Medical Marijuana Program. I authorize the Michigan Secretary of State's office to forward my photograph to the Michigan Medical Marijuana Program to be printed on my registry identification card.

Signature of Parent/Legal Guardian: _____ **Date:** _____

CANNABIS
REGULATORY AGENCY

www.michigan.gov/mmp

(517) 284-6400

Declaration of Person Responsible for MINOR Patient

Declaration by Parent or Legal Guardian

To be signed and completed by the patient's parent or legal guardian

This Declaration of Person Responsible form must be completed and submitted with the MINOR application packet. Only the parent or legal guardian can serve as the primary caregiver for a minor patient. A copy of proof of parentage or legal guardianship (i.e., birth certificate or court order, etc.) must be submitted with a MINOR Application or the application will be denied. If there has been a name change for the caregiver, please include all documents of legal name change leading up to current legal name of the caregiver (i.e., marriage license, divorce decree, etc.)

I declare each of the below statements is true and accurate:

- The patient's physicians have explained to the patient and me the potential risks and benefits of the medical use of marijuana.
- I consent to the patient's medical use of marijuana.
- I agree to serve as the patient's designated caregiver.
- I agree to control the acquisition, dosage, and frequency of the medical use of the marijuana by the patient.

Section D: Parent/Legal Guardian Signature & Date

I attest the information provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, 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 Parent/Legal Guardian: _____ **Date:** _____

Michigan Medical Marijuana Program
www.michigan.gov/mmp
(517) 284-6400

CANNABIS REGULATORY AGENCY

Physician Certification Form 1 of 2

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who holds an active license to practice in the state of Michigan.

Section A: Certifying Physician Information (name as it appears on medical license)

Legal First Name	Middle Initial	Legal Last Name

Current Mailing Address including Apartment/Suite/Lot #

City	State	Zip Code	Telephone Number

Michigan Physician License Number (enter only 10 digits)

M.D. _ _ _ _ _ _ _ _ _ _ **D.O.** _ _ _ _ _ _ _ _ _ _

Section B: Patient Information

Legal First Name	Middle Initial	Legal Last Name

Date of Birth (MM/DD/YY)

Section C: Patient's Debilitating Medical Condition(s)

This patient has been diagnosed with the following debilitating medical condition(s): (A minimum of one box must be checked in at least one of the following categories.)

Category A	Category B	Category C
□ Cancer	A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following:	□ Post-Traumatic Stress Disorder
□ Glaucoma	□ Cachexia or Wasting Syndrome	□ Obsessive Compulsive Disorder
□ HIV Positive	□ Severe and Chronic Pain	□ Arthritis
□ AIDS	□ Severe Nausea	□ Rheumatoid Arthritis
□ Hepatitis C	□ Seizures (including but not limited to those characteristic of epilepsy)	□ Spinal Cord Injury
□ Amyotrophic Lateral Sclerosis	□ Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of multiple sclerosis)	□ Colitis
□ Crohn's Disease		□ Inflammatory Bowel Disease
□ Agitation of Alzheimer's Disease		□ Ulcerative Colitis
□ Nail Patella		□ Parkinson's Disease
		□ Tourette's Syndrome
		□ Autism
		□ Chronic Pain
		□ Cerebral Palsy

Section D: Certification, Signature, & Date

By signing below, I attest that the information entered on this certification is true and accurate. I attest that I am in compliance with the Michigan Medical Marihuana Act and associated administrative rules and have a bona fide physician-patient relationship with this patient. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation. Further, I attest that in my professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the debilitating medical condition identified above or symptoms associated with that condition.

Signature of Physician: _____ **Date:** _____

Michigan Medical Marijuana Program
www.michigan.gov/mmp
(517) 284-6400

CANNABIS REGULATORY AGENCY

Physician Certification Form 2 of 2

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who holds an active license to practice in the state of Michigan.

Section A: Certifying Physician Information (name as it appears on medical license)

Legal First Name	Middle Initial	Legal Last Name

Current Mailing Address including Apartment/Suite/Lot #

City	State	Zip Code	Telephone Number

Michigan Physician License Number (enter only 10 digits)

M.D. _ _ _ _ _ _ _ _ _ _ **D.O.** _ _ _ _ _ _ _ _ _ _

Section B: Patient Information

Legal First Name	Middle Initial	Legal Last Name

Date of Birth (MM/DD/YY)

Section C: Patient's Debilitating Medical Condition(s)

This patient has been diagnosed with the following debilitating medical condition(s): (A minimum of one box must be checked in at least one of the following categories.)

Category A	Category B	Category C
□ Cancer	A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following:	□ Post-Traumatic Stress Disorder
□ Glaucoma	□ Cachexia or Wasting Syndrome	□ Obsessive Compulsive Disorder
□ HIV Positive	□ Severe and Chronic Pain	□ Arthritis
□ AIDS	□ Severe Nausea	□ Rheumatoid Arthritis
□ Hepatitis C	□ Seizures (including but not limited to those characteristic of epilepsy)	□ Spinal Cord Injury
□ Amyotrophic Lateral Sclerosis	□ Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of multiple sclerosis)	□ Colitis
□ Crohn's Disease		□ Inflammatory Bowel Disease
□ Agitation of Alzheimer's Disease		□ Ulcerative Colitis
□ Nail Patella		□ Parkinson's Disease
		□ Tourette's Syndrome
		□ Autism
		□ Chronic Pain
		□ Cerebral Palsy

Section D: Certification, Signature, & Date

By signing below, I attest that the information entered on this certification is true and accurate. I attest that I am in compliance with the Michigan Medical Marihuana Act and associated administrative rules and have a bona fide physician-patient relationship with this patient. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation. Further, I attest that in my professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the debilitating medical condition identified above or symptoms associated with that condition.

Signature of Physician: _____ **Date:** _____