CANNABIS REGULATORY AGENCY

www.michigan.gov/mmp

(517) 284-8599

For Official Use Only
No Fee

Add or Change Caregiver Amendment

This form is for active registered **Patients** who are adding or changing their caregiver.

Instructions

1. Complete the entire form.
   a. Patient: Include a copy of patient's valid Michigan driver license, OR personal identification card, OR signed voter registration. If a patient submits a voter registration, they shall also submit a copy of a government-issued document that includes the patient's name and date of birth for verification purposes.
   b. Caregiver: Include copy of new caregiver's valid state-issued driver license, OR personal identification card.
2. This form must be signed and dated within 6 months of being received by the MMMP.
3. Keep a copy of all documents for your records.
4. Mail completed form and all required documents in one envelope to:

Michigan Medical Marijuana Program
PO Box 30083
Lansing, MI 48909

Section A: Patient Information (must already have an active Registry Card in the Program)

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
	MI	

Section B: Person Allowed to Possess Patient's Marijuana Plants

Select only one box.

☐ I will possess the plants.

☐ My caregiver will possess the plants.

Section C: New 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

Other Names Used by Caregiver (maiden names, nicknames, etc.)

Section D: Patient/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 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. 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 Patient: _____ **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. Further, I agree to serve as the patient's primary caregiver, have no convictions that will disqualify me from serving as a primary caregiver, and authorize the department to use the information provided 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 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 Caregiver: _____ **Date:** _____