

Caregiver Change Form Instructions

1. **Make checks or money orders payable to: State of Michigan-MMMP**
2. Keep a copy of all documents submitted for your records.
3. Mail Change Form and all required documentation (see below) in one envelope to:

Michigan Medical Marihuana Program
PO Box 30083
Lansing, MI 48909

Caregiver Change Form Checklist

Name Change

Legal documentation*
Signed & dated Change Form
Copy of Caregiver's valid MI photo ID
\$10 Fee

Address Change

Signed & dated Change Form
Copy of Caregiver's valid MI photo ID **
\$10 Fee per card

Removing a Patient

Signed & dated Change Form
Copy of Caregiver's valid MI photo ID**
\$10 Fee per patient removed

Request Replacement Caregiver Card(s)

Signed & dated Change Form
Copy of Caregiver's valid MI photo ID**
\$10 Fee per card

* Certified court document supporting name change: ie. marriage/divorce decree, legal name change document, valid MI driver's license or Michigan ID, etc

** A copy of a valid MI driver's license, MI identification card or MI voter registration. Cannot accept expired photo IDs.



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

Office Use Only

Michigan Medical Marihuana Program Caregiver Change Form

Caregiver Information – As it appears on your current registry ID card. *(Required)*

Caregiver Registry ID Card Number C	Date of Birth	Telephone Number	
Legal First Name	Middle Initial	Legal Last Name	Suffix (Jr., Sr., III., etc.)

Caregiver Name Change

Legal First Name	Middle Initial	Legal Last Name	Suffix
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Caregiver Address Change

Mailing Address		Apartment/Suite/Lot #	
City	State	Zip Code	

Remove Current Patient(s)

1. Name of current Patient:
2. Name of current Patient:
3. Name of current Patient:
4. Name of current Patient:
5. Name of current Patient:

Request Replacement Caregiver Card(s)

1. Card Registry ID number or Patient Name:
2. Card Registry ID number or Patient Name:
3. Card Registry ID number or Patient Name:
4. Card Registry ID number or Patient Name:
5. Card Registry ID number or Patient Name:

Caregiver Signature & Declaration *(Required)*

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.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Caregiver: X Date: _____