CANNABIS REGULATORY AGENCY

This packet contains the adult 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. Below are the two ways in which you can apply/renew.

Apply or Renew online

- Go to www.michigan.gov/mmp
- You must be an adult patient 18 and older without a caregiver (or removing a caregiver if renewing) and create a secure online account. If you are currently an active patient and want to keep your caregiver or apply with one, you must apply by mail.
- You must have a medical evaluation from an active, licensed Michigan physician. If you are renewing, you must be recertified by a physician.
- **Only online applicants will receive their approval or denial by email.**

Instructions to Apply or Renew by paper via mail

- Use the most up to date application found at www.michigan.gov/mmp
- The application and physician certification must be signed & dated within 6 months from the date they are received by the MMMP.
- If you are acting as either the legal guardian or Medical Durable Power of Attorney (MDPOA) for the applicant, you must submit a copy of proof of legal guardianship or MDPOA with signatory authority along with the application. The legal guardian or MDPOA must also submit a copy of his or her proof of Michigan residency (see below). If your MDPOA has a specific condition that must be met before it becomes activated, you must submit proof those conditions (e.g., proof the patient is incapacitated) have been met. The MDPOA or Legal Guardian must sign in place of the patient.
- Any use of white-out or changes to the application form or physician certification form will result in the denial of your application.
- Keep a copy of all documents for your records.
- Patient proof of Michigan residency can be a valid, clear copy of a Michigan driver license, OR a personal ID issued by the Michigan Secretary of State, OR a signed voter registration. Only the front is required.
  - 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.
- 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. Application Form for Registry Identification Card.
- ☐ 2. Physician Certification Form.
- ☐ 3. Proof of Michigan Residency for the patient.
- ☐ 4. Application fee of $40. This can be a check or money order payable to: **State of Michigan-MMMP**
- ☐ 5. If you are designating a caregiver, you must include a copy of the caregiver's valid state-issued driver license or personal identification card. Only the front is required.

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Michigan Medical Marijuana Program
PO Box 30083
Lansing, MI 48909

www.michigan.gov/mmp
(517) 284-8599

For Official Use Only
$40 Fee Required

Application Form for Registry Identification Card

See page 1 for instructions and online application options.

Section A: Patient 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
	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: Caregiver Information (required only if designating a caregiver)

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 name(s), 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. I authorize the release of my protected health information, which includes the information contained in the form completed by my certifying physician, to the Michigan Medical Marijuana Program.

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. I agree to serve as the patient's primary caregiver, am at least 21 years old, have no convictions that disqualify me from serving as primary caregiver, and authorize the Michigan Medical Marijuana Program 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 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:** _____

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Michigan Medical Marijuana Program
www.michigan.gov/mmp
(517) 284-8599

Physician Certification Form

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

- ☐ Cancer
- ☐ Glaucoma
- ☐ HIV Positive
- ☐ AIDS
- ☐ Hepatitis C
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Crohn's Disease
- ☐ Agitation of Alzheimer's Disease
- ☐ Nail Patella

Category B

A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following:

- ☐ 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)

Category C

- ☐ Post-Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Spinal Cord Injury
- ☐ Colitis
- ☐ Inflammatory Bowel Disease
- ☐ Ulcerative Colitis
- ☐ 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:** _____