LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

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

For Official Use Only
☐ $10 Fee Received

Remove Patient Form

This form is for active registered CAREGIVERS who are removing one or more current PATIENT(S). You may also change your address at this time. If a new address is listed, we'll update your address on all active registry cards. Only one address is allowed per person in the program.

INSTRUCTIONS

1. Complete Sections A and B.
2. Sign and date the form.
3. Include a copy of your valid state-issued driver license or personal identification card.
4. Include check or money order for $10 made payable to: **State of Michigan-MMMP** (If you are removing more than 1 patient, $10 will cover all of the patients being removed).
5. Make a copy of the completed form and all required documentation for your records.
6. Do not include any other forms, fees, or documentation in the envelope.
7. Mail completed form and **all** required documentation in **one** envelope to:

Michigan Medical Marihuana Program
P.O. Box 30083
Lansing, MI 48909

☐ **Section A: Caregiver Information (As it appears on your current registry card)** ***(REQUIRED)***

Legal First Name	Middle Initial	Legal Last Name	Suffix (Jr., Sr., etc.)

Date of Birth	Telephone Number

Mailing Address (If your address has changed, provide your new address) Apartment/Suite/Lot #

City	State	Zip Code

☐ **Section B: Remove Patient(s)** ***(REQUIRED)***

1. Name of patient being removed:
2. Name of patient being removed:
3. Name of patient being removed:
4. Name of patient being removed:
5. Name of patient being removed:

Caregiver Signature and 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.*) 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: X _____ **Date:** _____