DCH/MMP-501 (3/09)

Michigan Department of Community Health
Michigan Medical Marihuana Program
P.O. Box 30083
Lansing, MI 48909
www.michigan.gov/mmp

Instructions for Applying for a Medical Marihuana Registry Identification Card for Minor Patient

To be eligible for the Michigan Medical Marihuana Registry, you must complete the application packet and submit the following information:

☐ **APPLICATION FOR IDENTIFICATION CARD**
- Please complete the entire application form.
- Complete the physician information.
- Sign and date the application.

☐ **PHYSICIAN CERTIFICATION – TWO (2) COMPLETED CERTIFICATIONS FROM MICHIGAN LICENSED MDs/DOs**
- Two physicians must complete and sign the physician certification forms.

☐ **DOCUMENTATION OF LEGAL GUARDIANSHIP**

☐ **DECLARATION OF PERSON RESPONSIBLE FOR A MINOR APPLYING TO PARTICIPATE IN THE MICHIGAN MEDICAL MARIHUANA REGISTRY**

☐ **PHOTO ID**

☐ **$100.00 APPLICATION FEE (Check or money order payable to State of Michigan—MMMP. $25.00 if enrolled in Medicaid Health Plan or receiving SSI.)**

☐ **DOCUMENTATION VERIFYING RECEIPT OF BENEFITS FROM STATE OR FEDERAL AGENCIES (IF APPLICABLE)**

☐ **SEND ALL OF THE ITEMS TO:**

Michigan Department of Community Health
Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909

The information you provide will be verified within 15 days of receiving the application. If approved, your card will be issued and sent to the address provided.

Your application will be denied if determined incomplete. You can resubmit your application with all of the necessary information for reconsideration without an additional fee for up to one year from the date your first application was received.

If the information you provide on the application is determined to be false at any time, your registration card will become null and void.

The applicant will receive one card with the patient's information. A separate card with the patient caregiver information will be sent to the parent/legal guardian.

Keep copies of all the documents you send to the Michigan Marihuana Registry. These are proof that your application is in process.

If you have questions, contact the Michigan Medical Marihuana Registry at (517) 373-0395.

Forms are available at http://www.michigan.gov/mmp.

DCH/MMP-011 (3/09)

Michigan Department of Community Health
Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
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FOR OFFICIAL USE ONLY

APPLICATION FORM FOR REGISTRATION OF MINOR PATIENT

INSTRUCTIONS: Please complete all required information to comply with the registration requirements of the Michigan Medical Marihuana Registry. Attach readable copies of ID and your application fee. The custodial parent or legal guardian with responsibility for health care decisions must be listed as the primary caregiver for patients under 18.

PLEASE TYPE OR PRINT LEGIBLY

APPLICANT INFORMATION: *(REQUIRED)*

NAME (Last, First, M.I.)			☐ Male ☐ Female
SOCIAL SECURITY NUMBER / /			DATE OF BIRTH / /
MAILING ADDRESS			TELEPHONE NUMBER ( )
CITY	STATE MI	ZIP CODE	EMAIL ADDRESS (Optional)

Photo Identification: A clear photocopy of one of the following must be attached. Please check appropriate box:
☐ MI Driver's License #____________________ ☐ MI ID Card #____________________ ☐ Other____________________

PARENT OR LEGAL GUARDIAN WHO IS RESPONSIBLE FOR MARIHUANA: *(REQUIRED)*

NAME (Last, First, M.I.)			☐ Male ☐ Female
SOCIAL SECURITY NUMBER / /			DATE OF BIRTH / /
MAILING ADDRESS			TELEPHONE NUMBER ( )
CITY	STATE MI	ZIP CODE	EMAIL ADDRESS (Optional)

Photo Identification: A clear photocopy of one of the following must be attached. Please check appropriate box:
☐ MI Driver's License #____________________ ☐ MI ID Card #____________________ ☐ Other____________________

PHYSICIAN INFORMATION: *(REQUIRED)*

1. PHYSICIAN'S NAME	MI LICENSE NUMBER	TELEPHONE NUMBER ( )
2. PHYSICIAN'S NAME	MI LICENSE NUMBER	TELEPHONE NUMBER ( )

REGISTRATION FEE: *(REQUIRED)*

The registration fee is $100.00 ($25.00 if enrolled in Medicaid Health Plan or receiving SSI). Enclose your check or money order made payable to *State of Michigan—MMMP*. We do not accept Credit or Debit Cards. Attach proof/verification/documentation of your Medicaid or SSI eligibility.

SIGNATURE & DATE: *(REQUIRED)*

☐ I ATTEST THAT THE ABOVE INFORMATION IS TRUE.

I UNDERSTAND THAT LAW ENFORCEMENT PERSONNEL CAN VERIFY THE VALIDITY OF MY REGISTRATION NUMBER ONLY.

☐ I AUTHORIZE THE RELEASE OF MY NAME AND DATE OF BIRTH TO CONFIRM IDENTITY ONLY IF A VALID REGISTRATION NUMBER HAS BEEN PROVIDED BY LAW ENFORCEMENT PERSONNEL.

☐ I DO NOT AUTHORIZE THE RELEASE OF ANYTHING BUT THE STATUS OF MY REGISTRATION NUMBER.

____ ____________________
Applicant's Signature Date

____ ____________________
Parent's or Legal Guardian's Signature Date

DCH/MMP-020 (3/09)

Michigan Department of Community Health
Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
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Physician Certification #1

INSTRUCTIONS: Please complete all of the information required on this form OR provide relevant portions of the patient's medical record that contain all the information required on this form. Sign the form and keep a copy in the patient's medical record. The patient will submit this certification along with his/her application for a Michigan Medical Marihuana Registry identification card. This does not constitute a prescription for marihuana. You may contact the Michigan Medical Marihuana Registry at (517) 373-0395 if you have any questions or concerns.

PLEASE TYPE OR PRINT LEGIBLY

PATIENT INFORMATION: *(REQUIRED)*

Name (Last, First, M.I.)	DATE OF BIRTH
	/ /

PHYSICIAN INFORMATION: *(REQUIRED)*

Name (Last, First, M.I.)			TELEPHONE NUMBER
			( )
MAILING ADDRESS			MI LICENSE NUMBER
CITY	STATE	ZIP CODE	EMAIL ADDRESS (Optional)

PHYSICIAN'S STATEMENT: *(REQUIRED)*

The above-named patient has been diagnosed with and is currently undergoing treatment for the following debilitating medical condition (check appropriate boxes):

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

OR a medical condition or treatment that produces, for this patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of medical marihuana.

- ☐ 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.)

Comments: (Please Type or Print Legibly)

SIGNATURE & DATE: *(REQUIRED)*

I hereby certify that I am a physician licensed to practice medicine in Michigan. I have responsibility for the care and treatment for the above-named patient. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated above. The medical use of marihuana is likely to be palliative or provide therapeutic benefits for the symptoms or effects of applicant's condition. This is not a prescription for the use of medical marihuana.

Physician's Signature	Date

Provide the name and telephone number of office contact to verify validity of certification:

(Name – Please Print)	( ) (Telephone Number)

DCH/MMP-020 (3/09)

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Michigan Medical Marihuana Registry
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Physician Certification #2

INSTRUCTIONS: Please complete all of the information required on this form OR provide relevant portions of the patient's medical record that contain all the information required on this form. Sign the form and keep a copy in the patient's medical record. The patient will submit this certification along with his/her application for a Michigan Medical Marihuana Registry identification card. This does not constitute a prescription for marihuana. You may contact the Michigan Medical Marihuana Registry at (517) 373-0395 if you have any questions or concerns.

PLEASE TYPE OR PRINT LEGIBLY

PATIENT INFORMATION: *(REQUIRED)*

Name (Last, First, M.I.)	DATE OF BIRTH
	/ /

PHYSICIAN INFORMATION: *(REQUIRED)*

Name (Last, First, M.I.)			TELEPHONE NUMBER
			( )
MAILING ADDRESS			MI LICENSE NUMBER
CITY	STATE	ZIP CODE	EMAIL ADDRESS (Optional)

PHYSICIAN'S STATEMENT: *(REQUIRED)*

The above-named patient has been diagnosed with and is currently undergoing treatment for the following debilitating medical condition (check appropriate boxes):

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

OR a medical condition or treatment that produces, for this patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of medical marihuana.

- ☐ 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.)

Comments: (Please Type or Print Legibly)

SIGNATURE & DATE: *(REQUIRED)*

I hereby certify that I am a physician licensed to practice medicine in Michigan. I have responsibility for the care and treatment for the above-named patient. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated above. The medical use of marihuana is likely to be palliative or provide therapeutic benefits for the symptoms or effects of applicant's condition. This is not a prescription for the use of medical marihuana.

______________________ Physician's Signature ______________ Date

Provide the name and telephone number of office contact to verify validity of certification:

( )

(Name – Please Print) **(Telephone Number)**

DCH/MMP-040 (3/09)

Michigan Department of Community Health
Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
www.michigan.gov/mmp

Declaration of Person Responsible for a Minor Applying to Participate in the Michigan Medical Marihuana Registry (Parent or Legal Guardian)

INSTRUCTIONS: Please complete all required information in order to comply with the requirements of the Michigan Medical Marihuana Registry. This form is required in addition to the patient application form if the patient is under 18 years of age.

PLEASE TYPE OR PRINT LEGIBLY

DECLARATION: *(REQUIRED)*

I, ____, do hereby declare:

That I am the Parent/Legal Guardian ***(circle one)*** with responsibility for health care decisions for:

____

Applicant's Name

- The applicant's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marihuana.
- I consent to the use of marihuana by the applicant for medical purposes.
- I agree to serve as the applicant's designated primary caregiver.
- I agree to control the acquisition of marihuana and the dosage and frequency of use by the applicant.
- I have provided statements of certification regarding the patient's status from two (2) licensed physicians.

PARENT OR LEGAL GUARDIAN INFORMATION: *(REQUIRED)*

ADDRESS			TELEPHONE NUMBER ( )
CITY	STATE MI	ZIP CODE	EMAIL ADDRESS (Optional)
RELATIONSHIP TO APPLICANT			
SOCIAL SECURITY NUMBER OF PARENT OR LEGAL GUARDIAN / /			

____ ____________________

Parent's or Legal Guardian's Signature **Date**