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

Instructions for Applying for a Medical Marihuana Registry Identification Card

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.
- You may choose to designate a primary caregiver, although you do not have to. A caregiver is defined as "a person who is at least 21 years old and who has agreed to assist with a patient's medical use of marihuana and who has never been convicted of a felony involving illegal drugs."
- Identify who is responsible for the patient's marihuana plants.
- Sign and date the application.

☐ **PHYSICIAN CERTIFICATION FROM MICHIGAN LICENSED MD/DO**

- Your physician must complete and sign the physician certification form.

☐ **CAREGIVER ATTESTATION (IF APPLICABLE)**

☐ **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
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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 primary caregiver, if designated.

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.

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APPLICATION FORM FOR REGISTRATION

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.

PLEASE TYPE OR PRINT LEGIBLY

APPLICANT INFORMATION: *(REQUIRED)*

NAME (Last, First, M.I.) ☐ Male ☐ Female

SOCIAL SECURITY NUMBER / / **DATE OF BIRTH** / /

MAILING ADDRESS **PHONE 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**_____

PRIMARY CAREGIVER: *(IF APPLICABLE)*

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**_____

PERSON RESPONSIBLE FOR PATIENT'S MARIHUANA PLANTS: *(REQUIRED)*

NAME (Last, First, M.I.) ☐ Male ☐ Female **DATE OF BIRTH** / /

PHYSICIAN INFORMATION: *(REQUIRED)*

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**

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Physician Certification

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 Program 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:

Name (Last, First, M.I.) | **TELEPHONE NUMBER** ( )

MAILING ADDRESS | **MI LICENSE NUMBER**

CITY | **STATE** | **ZIP CODE** | **EMAIL ADDRESS**

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 or 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)** ( )

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Caregiver Attestation

INSTRUCTIONS: Please complete all required information in order to comply with the requirements of the Michigan Medical Marihuana Registry.

PLEASE TYPE OR PRINT LEGIBLY

DECLARATION: *(REQUIRED)*

I, _____, do hereby declare:

That I am willing and able to serve as the primary caregiver for:

_____
Applicant's Name

I further certify that:

- I am at least 21 years of age.
- I have never been convicted of a felony offense involving illegal drugs.
- I understand that my caregiver registration will become null and void if I am convicted of a felony offense involving illegal drugs.
- I am a caregiver for no more than 5 patients.

SOCIAL SECURITY NUMBER: *(REQUIRED)*

/ /

PRIMARY CAREGIVER INFORMATION: *(REQUIRED)*

ADDRESS			TELEPHONE NUMBER ( )
CITY	**STATE** MI	**ZIP CODE**	**EMAIL ADDRESS** (Optional)

I understand that it is necessary to secure a criminal conviction history as part of the screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial recordkeeping organization to verify if I have been convicted of any felony offenses involving illegal drugs. The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my registration and that such misrepresentation is punishable by law.

_____ _____
Signature of Primary Caregiver **Date**