LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Application Instructions and Checklist

(517)373-0395 | www.michigan.gov/mmp

Instructions for applying to the Michigan Medical Marihuana Program

Instructions

1. Mail only **one** complete application and **all** required documentation (see below) in **one** envelope to:

   Michigan Medical Marihuana Program
   PO Box 30083
   Lansing, MI 48909

2. **Make checks or money orders payable to: State of Michigan-MMMP**
3. This application is for a person who is 18 years of age or older and a resident of Michigan.
4. Please type or print legibly when completing the application.
5. The original signed Application Form and Physician Certification Form must be submitted to the MMMP. Make sure to keep a copy of the completed Application and Physician Certification Form for your records.

Checklist

☐ **Application Form for Registry Identification Card**

- Any use of white-out on or alterations to the Application Form will result in the denial of your application.
- **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 with the application. The MDPOA or legal guardian must also submit a copy of their valid photo ID (see copy of valid photo ID below).

☐ **Application Fee: $100**

- A patient who currently receives **full Medicaid benefits or Supplemental Security Income (SSI)** and **submits the appropriate supporting documentation** is eligible for a reduced registration fee. The reduced registration fee is $25.00. Examples of acceptable supporting documentation are available on our website at: www.michigan.gov/mmp.

☐ **Copy of Valid Photo ID** (Michigan Driver's license, Michigan ID card, or other acceptable form of ID)

- The copy of the photo ID must be clear and legible.
- If you submit a copy of a photo ID that is not a Michigan driver's license or Michigan ID card, you must also submit a copy of your Michigan voter's registration card as proof of residency.

☐ **Physician Certification Form**

- A complete Physician Certification Form must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan.
- Any use of white-out on or alterations to the Physician Certification Form will result in the denial of your application.

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For Official Use Only MMP 3501 (Rev. 12/13)

Michigan Medical Marihuana Program
Application Form for Registry Identification Card

Section A: Patient Information *(REQUIRED)*

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4. Patient Registry ID Card Number (For Renewals Only)	5. MI Driver's License# or MI ID Card #	6. Date of Birth (MM/DD/YYYY)
P		

7a. Mailing Address	7b. Apartment/Suite/Lot #

8. City	9. State	10. Zip Code
	MI	

11. Email Address (If provided, you agree to receive email correspondence from MMMP)	12. Telephone Number

Section B: Person Allowed to Possess Patient's Marihuana Plants: *(REQUIRED)*

13. Plant possession: You must select one box. Failure to do so will result in the denial of your application.

SELECT ONLY ONE:
- ☐ I will possess the plants
- ☑ My caregiver will possess the plants

Section C: Caregiver Information *(If the patient is designating a caregiver)*

14. Legal First Name	15. Middle Initial	16a. Legal Last Name	16b. Suffix (Jr., Sr., III, etc.)

17. Caregiver Registry Card ID Number (For Renewals Only)	18. MI Driver's License# or MI ID Card #	19. Date of Birth (MM/DD/YYYY)
C		

20a. Mailing Address	20b. Apartment/Suite/Lot #

21. City	22. State	23. Zip Code
	MI	

24. Email Address (If provided, you agree to receive email correspondence from MMMP)	25. Telephone Number

26. Other Names Used by Caregiver (Nick names, maiden names etc. Use a separate piece of paper if you need space for additional names)

Section D: Patient Signature & Date *(Required)*

By signing below, I attest that the information entered on this application is true and accurate. I am aware that a false or dishonest answer may be grounds for the denial or nullification of my registration and such misrepresentation is punishable by law. I attest that I have designated the person listed in Section C to serve as my caregiver (if a person is listed). I understand that I am required to know and comply with the requirements of the Michigan Medical Marihuana Act, Administrative Rules, and all amendments.

Signature of Applicant/Patient: X _____ **Date:** _____

Section E: Caregiver Attestation: *(Required if the patient is designating a caregiver)*

By signing below, I attest that the information entered on this application is true and accurate. I am aware that a false or dishonest answer may be grounds for the denial or nullification of my registration and such misrepresentation is punishable by law. I understand that I am required to know and comply with the Michigan Medical Marihuana Act, Administrative Rules, and all amendments. I authorize this agency to use the information I have provided 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 determine if I have been convicted of any of the felony offenses that would make me ineligible to be a caregiver. I declare that I am willing and able to serve as the caregiver for the patient listed in Section A.

Signature of Caregiver: X _____ **Date:** _____

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Michigan Medical Marihuana Program

Physician Certification Form

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This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan

Section A: Certifying Physician Information *(Required)*

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4a. Full Mailing Address	4b. Apartment/Suite/Lot #

5. City	6. State	7. Zip Code	8. Telephone Number
			( ) -

9. Michigan Physician License Number

☐ **M.D. 4301** __ __ __ __ __ __ ☐ **D.O. 5101** __ __ __ __ __ __

Section B: Patient Information *(Required)*

10. Legal First Name	11. Middle Initial	12a. Legal Last Name	12b. Suffix (Jr., Sr., III, etc.)

13. Date of Birth

Section C: Patient's Debilitating Medical Condition(s) *(Required)*

This patient has been diagnosed with the following debilitating medical condition:
(A minimum of one box must be checked in at least one of the following categories.)

Category A	Category B	Category C
☐ Cancer ☐ Glaucoma ☐ HIV Positive or AIDS ☐ Hepatitis C ☐ Amyotrophic Lateral Sclerosis ☐ Crohn's Disease ☐ Agitation of Alzheimer's Disease ☐ Nail Patella	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.)	Check and list a condition **which has been approved** by the Medical Marihuana Review Panel: ☐ Approved medical condition: _____ _____ _____ _____ _____

Section D: Certification, Signature and Date (Required)

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, Administrative Rules, and all amendments. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, 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 marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

Signature of Physician: X _____ **Date:** _____