MMP 3500-1 (Rev. 6/13)

Department of Licensing and Regulatory Affairs
Michigan Medical Marihuana Registry
P.O. Box 30083, Lansing, MI 48909
517-373-0395 · www.michigan.gov/mmp

FOR OFFICIAL USE ONLY

APPLICATION FORM
for Registry Identification Card

MINOR Patient

- *For Applicants/Patients under 18 years of age*
- Please call our office if you have any questions

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

- Submit ALL documents in ONE envelope
- We recommend the parent/legal guardian submit the application packet
- Type or print legibly

☐ NEW: I have never applied before or my registry ID card is expired ☐ RENEWAL: My current registry ID card is not expired

For Renewals: Check any Changes: ☐ Patient Address Change ☐ Caregiver Address Change
☐ Patient Name Change ☐ Caregiver Name Change (Documents required for name changes; see question #2 on page 2)
☐ Patient Adding or Changing to New Caregiver (List the new caregiver's information in Section B)

Section A: APPLICANT/PATIENT INFORMATION: *(REQUIRED)*

For Renewals: Current Registry ID Card Number: P_____ ☐ Male ☐ Female

Legal Name (First):_____ (MI):_____ (Last):_____

Social Security Number:_____ Date of Birth:_____

Mailing Address:_____ (if applicable) Apt/Lot #_____

City:_____ Zip:_____ Phone Number (with area code):_____

Alternate Phone Number (with area code):_____

*You must complete Section B and refer to questions #7-8 on page 2.

Section B: CUSTODIAL PARENT OR LEGAL GUARDIAN: *(REQUIRED)*

For Renewals: If already registered to this patient, Current Registry ID Card Number: C_____ ☐ Male ☐ Female

Legal Name (First):_____ (MI):_____ (Last):_____

Social Security Number:_____ Date of Birth:_____

Mailing Address:_____ (if applicable) Apt/Lot #_____

City:_____ Zip:_____ Phone Number (with area code):_____

Alternate Phone Number (with area code):_____

Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS: *(REQUIRED)*

Only the parent or legal guardian listed in Section B is allowed to possess the minor applicant/patient's marihuana plants.

Michigan Medical Marihuana Registry
MINOR APPLICATION FORM

To ensure this application is complete, the Applicant/Patient must answer YES to all of the applicable questions below:

1. Are all of the fields correctly and legibly completed in Section A?..... ☐ YES
2. For renewals, is a copy of documentation provided for a name change? (if applicable)
   (I.e., marriage/divorce decree, legal name change document, valid MI driver license or Michigan ID, etc)…….. ☐ YES
3. Are all of the fields for the caregiver answered correctly and legibly in Section B?..... ☐ YES
4. Did both the applicant/patient and the parent/legal guardian sign and date this application in Section D below?..... (if #4 is NO, #5 must be YES) ☐ YES ☐ NO
5. OR, is a copy of a Durable Power of Attorney for Health Care or legal guardianship with signatory authority provided (if the applicant/patient is unable to sign this application)?..... (if #5 is NO, #4 must be YES) ☐ YES ☐ NO
6. Is a valid, clear copy (front and back) of the ***applicant/patient's*** photo ID provided (I.e., school ID)?..... ☐ YES ☐ NO
7. Is a valid, clear copy (front and back) of the ***custodial parent/legal guardian's*** Michigan driver license or Michigan ID provided OR his/her photo ID and Michigan voter registration provided?…….. ☐ YES
8. Is a copy of the Declaration for Person Responsible provided, correctly and legibly completed, by the ***custodial parent*** /legal guardian?..... ☐ YES
9. Are two (2) Physician Certifications (signed by 2 separate physicians) provided?..... ☐ YES
10. Is the $100.00 Registration Fee included, payable to State of Michigan-MMMP?..... (if #10 is NO, #11 must be YES) ☐ YES ☐ NO

    Enter the $100.00Check or Money Order #_____
11. OR, if the applicant/patient is eligible for the reduced fee, is the $25.00 Registration Fee included, payable to State of Michigan-MMMP? (Additional documents required-See #12)…….. (if #11 is NO, #10 must be YES) ☐ YES ☐ NO

    Enter the $25.00 Check or Money Order #_____ (if applicable)
12. Is the applicant/patient's acceptable supporting documentation for the reduced fee included?..... ☐ YES
    Examples of acceptable supporting documentation for the reduced fee are available at www.michigan.gov/mmp.
13. Check the program the applicant/patient is currently enrolled in which qualifies him/her for the reduced fee:
    ☐ Full Medicaid ☐ Supplemental Security Income (SSI)
14. Make a copy for your records and mail only one complete application, the check or money order, and all required documentation in one envelope to: **Michigan Medical Marihuana Registry Program · PO Box 30083 · Lansing, MI 48909**

Section D: ATTESTATION, SIGNATURE, & DATE: *(REQUIRED)*

By signing below, I attest that the information I have entered on this application is true and accurate:

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

▶ Signature of Parent/Legal Guardian: X _____ Date: _____

WHAT TO EXPECT AFTER YOU SUBMIT YOUR APPLICATION:

1. When your application is received by our office it will be approved or denied within 15 business days.
2. If this application is denied, the parent/legal guardian will receive a certified letter of explanation. You can then resubmit a copy of the application, with all required documents, for reconsideration up to 2 years from the date the fee is received.
3. If this application is approved, it will be processed in the date order received. The patient and caregiver will be issued and sent a registry ID card to the mailing address provided on this application.
4. If you have not received a denial letter, an approval letter, or some form of notification within six (6) weeks from the date the MMP receives your valid application, please contact our office at 517-373-0395 and select option #3. Please allow a full 6 weeks.
5. After submitting this application, any changes to your record (address, caregiver, name, etc.), prior to your registry ID card's expiration, should be submitted on a Change Form with the required fee. We recommend not submitting a Change Form within 60 days of submitting your renewal application.

MMP 3500-2 (Rev. 6/13)

Michigan Medical Marihuana Registry

Declaration of Person Responsible

for a MINOR Patient

Applying to Participate in the Michigan Medical Marihuana Registry

To be signed and completed by applicant/patient's Custodial Parent or Legal Guardian Only

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

TYPE OR PRINT LEGIBLY

This Declaration of Person Responsible must be completed and submitted with the MINOR application packet if the applicant/patient is under 18 years of age. Only the custodial parent or legal guardian can be the primary caregiver for a minor patient.

IF YOU ARE INELIGIBLE AS A CAREGIVER, THE PATIENT WILL BE DENIED

DECLARATION BY CUSTODIAL PARENT OR LEGAL GUARDIAN: *(REQUIRED)*

I, _____, do hereby declare each of the
(Print CAREGIVER'S NAME above)

below statements are true and accurate:

Check ONE: ☐ Custodial Parent ☐ Legal Guardian

The designated caregiver must initial each line below:

___ The applicant/patient's physicians have explained, to the patient and me, the potential risks and benefits of the medical use of marihuana.

___ I consent to the applicant/patient's medical use of marihuana.

___ I agree to serve as the applicant/patient's designated primary caregiver.

___ I agree to control the acquisition of the marihuana, the dosage, and the frequency of the medical use of marihuana by the applicant/patient.

___ I have provided written certifications regarding the applicant/patient's status from two (2) MD or DO's fully licensed by the state of Michigan.

___ I have provided a clear copy (front and back) of my Michigan driver license or Michigan state ID (OR a clear copy [front and back] of my photo ID and Michigan voter registration) to submit with this application or change form.

___ I attest the applicant/patient is a Michigan resident and a clear copy of his/her photo ID is provided, if available (I.e., school ID).

___ I have never been convicted of ANY felony offense involving illegal drugs.

___ I have not been convicted of ANY felony offense within the past 10 years. (Attestations received on or after April 1, 2013)

___ I have never been convicted of ANY felony offense that is an assaultive crime listed below or defined in Section 9a of Chapter X of the code of criminal procedure, 1927 PA 175, MCL 770.9a. (Attestations received on or after April 1, 2013)

Threats/assault against employee of Family Independence Agency	Stalking or aggravated stalking	Felonious Assault
Assault with intent to do great bodily harm less than murder; assault by strangulation or suffocation	Assault with intent to commit felony not otherwise punished	Assault with intent to maim
Leading, taking, carrying away, decoying, or enticing away child under 14	Conduct proscribed under MCL 750.81 to 750.89 as felony; intent [to commit conduct against a pregnant individual in order to cause or which leads to a miscarriage or stillbirth, or other harm to the embryo or fetus]	Attempted murder, 1st or 2nd degree murder
Kidnapping/Prisoner taking person as hostage		Assault with intent to commit murder
Assault with intent to rob and steal; armed or unarmed		Assault with intent to commit CSC or CSC 1st, 2nd, 3rd, or 4th degree
Larceny of money or other property	[Terrorism: Violation of the Michigan Anti-Terrorism Act]	[Felonious Use of Explosives]
	Use or possession of dangerous weapon	Manslaughter
		Mayhem
		Carjacking

___ I understand that both the patient and caregiver registrations will become null and void if I am convicted of a felony offense.

___ I am willing, able, and eligible to serve as the primary caregiver for:

Print Applicant/Patient's Name: _____

MMP 3500-2 (Rev. 6/13)

Michigan Medical Marihuana Registry

Declaration of Person Responsible

for a MINOR Patient

Applying to Participate in the Michigan Medical Marihuana Registry

To be signed and completed by applicant/patient's Parent or Legal Guardian Only

All fields below must be completed.

CUSTODIAL PARENT OR LEGAL GUARDIAN INFORMATION: *(REQUIRED)*

Legal Name (First):_____ (MI):_____ (Last):_____

Social Security Number:_____ Date of Birth:_____

Mailing Address:_____ (if applicable) Apt/Lot #_____

City:_____ Zip:_____ Phone Number (with area code):_____

Alternate Phone Number (with area code):_____

List any maiden names or nick names used now or in the past that you, the caregiver (male or female) have used. Attach a separate page if more space is required.

OTHER NAMES USED BY CAREGIVER : *(IF APPLICABLE)*

Legal Name (First):_____ (MI):_____ (Last):_____

Legal Name (First):_____ (MI):_____ (Last):_____

Legal Name (First):_____ (MI):_____ (Last):_____

CAREGIVER DECLARATION: *(REQUIRED)*

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 of the felony offenses that would make me ineligible to be a caregiver. I have not withheld information that might affect the decision to be made on this application. In signing this attestation, I am aware that a false statement or dishonest answer may be grounds for denial or revocation of my registration and that such misrepresentation is punishable by law.

Signature of Parent/Legal Guardian: X _____ Date: _____

To ensure this declaration is complete, the caregiver (parent/legal guardian) must answer YES to all of the applicable questions below:

1. On page 1, did you, the caregiver, print your name in the designated area at the top?..... ☐ YES
2. On page 1, did you, the caregiver, initial each statement verifying your eligibility to be a caregiver?..... ☐ YES
3. On page 1, did you, the caregiver, print the applicant/patient's name in the designated area at the bottom?... ☐ YES
4. On page 2, did you, the caregiver, complete all fields correctly and legibly?..... ☐ YES
5. On page 2, did you, the caregiver, enter all other previous and current names used? (if applicable)..... ☐ YES
6. On page 2, did the caregiver and applicant/patient sign in the appropriate designated areas?..... ☐ YES
7. This Attestation must be submitted to the MMP with the appropriate application or change form for the MINOR.

MMP 3500-3 (Rev. 6/13)

Michigan Medical Marihuana Registry

Physician Certification #1 for Minor Patient

- Please encourage patients to submit their application packets as soon as possible after you sign this certification.

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery fully licensed by the state of Michigan.
This certification does not constitute a prescription for marihuana.*

CERTIFYING PHYSICIAN INFORMATION: *(REQUIRED)* **TYPE OR PRINT LEGIBLY**

Physician Name (First):_____ (MI):_____ (Last):_____

Full Address:_____

Phone Number (with area code):_____

Michigan Physician License Number: ☐ M.D. **4301**____ ____ ____ ____ ____ ____ *OR* ☐ D.O. **5101**____ ____ ____ ____ ____ ____

DECLARATION:

The physician must initial each line below:

I do hereby declare I am in compliance with the Michigan Medical Marihuana Act, Section 3a, which includes all of the following:

___ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))

___ I have created and will maintain records of this patient's condition in accord with medically accepted standards. (MCL333.26423(a)(2))

___ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))

___ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition. (MCL333.26423(a)(4))

For Minor Patients ONLY:

___ I have explained the potential risks and benefits of the medical use of marihuana to the qualifying patient and to his or her parent or legal guardian. (MCL333.26426(b)(1))

PATIENT INFORMATION: *(REQUIRED)* **TYPE OR PRINT LEGIBLY**

☐ Male ☐ Female Date of Birth:_____

Legal Name (First):_____ (MI):_____ (Last):_____

Date of this patient's in-person medical evaluation relating to this certification: _____

I certify that the above named patient has been diagnosed with the following debilitating medical condition (check appropriate box(es)):
A checkbox must be selected below and/or on page 2 for this patient.

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

☐ Other condition not listed, which has been approved as a qualifying condition pursuant to the Medical Marihuana Review Panel (MCL 333.26425a) _____

Physician's Comments (if applicable): (Please Type or Print Legibly)

MMP 3500-3 (Rev. 6/13)

Michigan Medical Marihuana Registry

Physician Certification

I certify that the named patient on page 1 of this certification has been diagnosed with a medical condition or treatment that produces, for this patient, one or more of the following and which, in this physician's professional opinion, may be alleviated by the medical use of marihuana (check appropriate box(es)):

Legibly print the medical condition or treatment

- ☐ 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.) _____

Physician's Comments (if applicable): (Please Type or Print Legibly)

CERTIFICATION, SIGNATURE, & DATE: *(REQUIRED)*

I hereby certify that I am a physician licensed to practice in Michigan. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated on this form. The medical use of marihuana is likely to provide palliative or therapeutic benefits for the symptoms or effects of the patient's condition. This is not a prescription for the use of medical marihuana. Additionally, if the patient ceases to suffer from the above identified debilitating condition, I hereby certify I will notify the Department in writing.

Signature of Physician: X _____ Date: _____

(Fully licensed Michigan MD or DO only)

PRINT the name and telephone number of contact person at the physician's office to verify validity of this certification:

Name: _____ Phone Number (with area code): _____

To ensure this certification is complete, the physician must answer YES to all of the applicable questions below:

1. On page 1, is the physician information complete with all fields correctly and legibly typed or printed in the Certifying Physician Information section?..... ☐ YES
2. On page 1, did you, the physician, initial each statement verifying compliance with the MMMA?..... ☐ YES
3. On page 1, is the patient information complete with all fields correctly and legibly typed or printed in the Patient Information section?..... ☐ YES

(Either #4 or #5 must be checked YES)

4. On page 1, did you, the physician, identify the qualifying debilitating medical condition(s) for this patient?..... ☐ YES
5. On page 2, did you, the physician, identify the qualifying diagnosis AND state the medical condition(s) or treatment for this patient?..... ☐ YES (Either #4 or #5 must be checked YES)
6. On page 2, did you, the physician, sign the Certification in the appropriate designated area?..... ☐ YES
7. Did you, the physician, give this Certification to the parent/legal guardian to submit with the patient's application?..... ☐ YES
8. Did you retain a copy of this Certification for this patient's records?..... ☐ YES

MMP 3500-4 (Rev. 6/13)

Michigan Medical Marihuana Registry

Physician Certification #2 for Minor Patient

- Please encourage patients to submit their application packets as soon as possible after you sign this certification.

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery fully licensed by the state of Michigan.
This certification does not constitute a prescription for marihuana.*

CERTIFYING PHYSICIAN INFORMATION: *(REQUIRED)* **TYPE OR PRINT LEGIBLY**

Physician Name (First):_____ (MI):_____ (Last):_____

Full Address:_____

Phone Number (with area code):_____

Michigan Physician License Number: ☐ M.D. **4301**____ ____ ____ ____ ____ ____ *OR* ☐ D.O. **5101**____ ____ ____ ____ ____ ____

DECLARATION:

The physician must initial each line below:

I do hereby declare I am in compliance with the Michigan Medical Marihuana Act, Section 3a, which includes all of the following:

___ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))

___ I have created and will maintain records of this patient's condition in accord with medically accepted standards. (MCL333.26423(a)(2))

___ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))

___ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition. (MCL333.26423(a)(4))

For Minor Patients ONLY:

___ I have explained the potential risks and benefits of the medical use of marihuana to the qualifying patient and to his or her parent or legal guardian. (MCL333.26426(b)(1))

PATIENT INFORMATION: *(REQUIRED)* **TYPE OR PRINT LEGIBLY**

☐ Male ☐ Female Date of Birth:_____

Legal Name (First):_____ (MI):_____ (Last):_____

Date of this patient's in-person medical evaluation relating to this certification: _____

I certify that the above named patient has been diagnosed with the following debilitating medical condition (check appropriate box(es)):
A checkbox must be selected below and/or on page 2 for this patient.

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

☐ Other condition not listed, which has been approved as a qualifying condition pursuant to the Medical Marihuana Review Panel (MCL 333.26425a) _____

Physician's Comments (if applicable): (Please Type or Print Legibly)

MMP 3500-4 (Rev. 6/13)

Michigan Medical Marihuana Registry
Physician Certification

I certify that the named patient on page 1 of this certification has been diagnosed with a medical condition or treatment that produces, for this patient, one or more of the following and which, in this physician's professional opinion, may be alleviated by the medical use of marihuana (check appropriate box(es)):

Legibly print the medical condition or treatment

- ☐ 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.) _____

Physician's Comments (if applicable): (Please Type or Print Legibly)

CERTIFICATION, SIGNATURE, & DATE: *(REQUIRED)*

I hereby certify that I am a physician licensed to practice in Michigan. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated on this form. The medical use of marihuana is likely to provide palliative or therapeutic benefits for the symptoms or effects of the patient's condition. This is not a prescription for the use of medical marihuana. Additionally, if the patient ceases to suffer from the above identified debilitating condition, I hereby certify I will notify the Department in writing.

Signature of Physician: X _____ Date: _____

(Fully licensed Michigan MD or DO only)

PRINT the name and telephone number of contact person at the physician's office to verify validity of this certification:

Name: _____ Phone Number (with area code): _____

To ensure this certification is complete, the physician must answer YES to all of the applicable questions below:

9. On page 1, is the physician information complete with all fields correctly and legibly typed or printed in the Certifying Physician Information section?..... ☐ YES
10. On page 1, did you, the physician, initial each statement verifying compliance with the MMMA?..... ☐ YES
11. On page 1, is the patient information complete with all fields correctly and legibly typed or printed in the Patient Information section?..... ☐ YES

(Either #4 or #5 must be checked YES)

12. On page 1, did you, the physician, identify the qualifying debilitating medical condition(s) for this patient?..... ☐ YES
13. On page 2, did you, the physician, identify the qualifying diagnosis AND state the medical condition(s) or treatment for this patient? (Either #4 or #5 must be checked YES) ..... ☐ YES
14. On page 2, did you, the physician, sign the Certification in the appropriate designated area?..... ☐ YES
15. Did you, the physician, give this Certification to the parent/legal guardian to submit with the patient's application?..... ☐ YES
16. Did you retain a copy of this Certification for this patient's records?..... ☐ YES