

****CHANGE FORM****

\$10.00 fee Required

- Please call our office if you have any questions
- Submit an Application Form (instead of the Change Form) if you are applying or renewing your registration or if your current card is expired
- Submit ALL documents in ONE envelope • We recommend the applicant/patient submit the change form packet • Type or print legibly
- Incomplete Change Forms will not be processed and a notice will be sent to the patient.

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

- Check ALL changes you are making to your registration:
- Patient Adding or Changing to New Caregiver (List the new caregiver's information in Section B)
 - Patient Mailing Address Change Caregiver Mailing Address Change Change Plant Possession
 - Patient Name Change Caregiver Name Change (Documents required for name changes; see question #2 on page 2)
- Remove Caregiver (No Caregiver)

Section A: PATIENT INFORMATION: (REQUIRED)

Current Registry ID Card Number: P _____ Do not submit this change form if you have not previously submitted an application to apply to the MMP Male Female

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

If Name Change, list:
Previous Name (First): _____ (MI): _____ (Last): _____

Social Security Number: _____ Date of Birth: _____

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

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

Alternate Phone Number (with area code): _____

****A patient who is 18 years of age or older is not required to designate a caregiver****

- ▶ If you have a caregiver, you must complete Section B and refer to questions #8-9 on page 2.
- ▶ Leave Section B blank ONLY if you are NOT designating a caregiver or are removing your caregiver.

****A patient who is under the age of 18, must retain a caregiver (custodial parent or legal guardian)****

- ▶ To change to a new caregiver, you must complete Section B and refer to questions #8-10 on page 2.

Section B: PRIMARY CAREGIVER INFORMATION: (IF APPLICABLE)

If already registered to this patient, Current Registry ID Card Number: C _____ Male Female

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

If Name Change, list:
Previous Name (First): _____ (MI): _____ (Last): _____

Social Security Number: _____ Date of Birth: _____

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

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

Alternate Phone Number (with area code): _____

Michigan Medical Marihuana Registry
CHANGE FORM

Plant possession will default to the Applicant/Patient if neither or both boxes are checked in Section C.

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

SELECT ONLY ONE: [] APPLICANT/PATIENT <----- [X] OR -----> [] PRIMARY CAREGIVER

(Only the parent or legal guardian listed in Section B is allowed to possess MINOR patient's marihuana plants)

To ensure this change form is complete, the Patient must answer YES to all of the applicable questions below:

- 1. Did you, the patient, answer all of the fields correctly and legibly in Section A?
2. Is a copy of documentation provided for a name change, if applicable?
3. Are all of the fields for the caregiver answered correctly and legibly in Section B
4. Is only one box checked in Section C for person who is allowed to possess the patient's Marihuana plants?
5. Did both the patient and the caregiver (if designated), sign and date this application in Section D below?
6. 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?
7. Is a valid, clear copy (front and back) of the patient's Michigan driver license or Michigan ID provided OR your photo ID and Michigan voter registration provided?
8. Is a valid, clear copy (front and back) of the caregiver's Michigan driver license or Michigan ID provided OR his/her photo ID and Michigan voter registration provided (if you, the patient, designated a caregiver in Section B)?
9. Is a copy of the Caregiver Attestation, correctly and legibly completed by the caregiver, provided (if you, the patient, designated a caregiver in Section B)?
10. Minors only- If changing to a new custodial parent or legal guardian, is a copy of legal guardianship papers provided?
11. Is the \$10.00 Change Form Fee included, payable to State of Michigan-MMMP?
12. Did you make a copy of this Change Form for your records?
13. Mail only one complete Change Form, the \$10.00 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: PATIENT SIGNATURE & DATE REQUIRED / CAREGIVER SIGNATURE & DATE IF DESIGNATED

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

Signature of Patient: X _____ Date: _____
Signature of Caregiver: X _____ Date: _____
For Minors: Signature of Parent/Legal Guardian: X _____ Date: _____

WHAT TO EXPECT AFTER YOU SUBMIT YOUR CHANGE FORM:

- 1. When your change form is received by our office it will be reviewed for completeness.
2. If this change form is deemed incomplete, the patient will receive a letter of explanation. A new change form can be resubmitted, with all required documents. The money submitted will remain on file until the expiration date on your current registry ID card.
3. If this change form is deemed complete, it will be processed in the date order received. The patient, and caregiver if designated, will be issued and sent a registry ID card to the mailing address(es) provided on this change form.
4. If the patient has not received a new registry ID card 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. 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.

Michigan Medical Marihuana Registry Caregiver Attestation

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

TYPE OR PRINT LEGIBLY

The person the applicant/patient is designating to be their primary caregiver must complete this form in its entirety. This form must be submitted by the applicant/patient along with his/her application or change form.

If the applicant/patient has never had a Michigan registry ID card or if the patient's card will expire within the next 60 days, they should submit this attestation with an application form. If the applicant/patient has recently submitted their application or renewal application, they should submit this attestation with a change form. If you have questions on which form to use, please contact the MMP at 517-373-0395.

DECLARATION: (REQUIRED)

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

below statements are true and accurate:

The designated caregiver must initial each line below:

- I am at least 21 years of age at the time I am signing this Attestation.
- I acknowledge at the time I am signing this Attestation I am not a caregiver for more than 5 qualifying patients.
- I will not possess more than 2.5 ounces of usable marihuana and 12 marihuana plants for this qualifying patient if the applicant/patient named below designates me to possess his/her marihuana plants on the application or change form submitted with this Attestation (see Section C of the application or change form).
- I have provided a front and back copy of my Michigan driver license or Michigan state ID (OR a front and back copy of my photo ID and Michigan voter registration) to this applicant/patient to submit his/her application or change form.
- 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 that is an assaultive crime as 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)
Some examples are listed below (this is not an all-inclusive list). If you have questions, please seek legal counsel.

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, 1 st or 2 nd degree murder
Kidnapping/Prisoner taking person as hostage	Felonious Use of Explosives (MCL750.200-MCL750.212a)	Assault with intent to commit murder
Assault with intent to rob and steal; armed or unarmed	Terrorism: Violation of the Michigan Anti-Terrorism Act (MCL750.543a-750.543z)	Assault with intent to commit CSC or CSC 1 st , 2 nd , 3 rd , or 4 th degree
Use or possession of dangerous weapon		Carjacking
		Manslaughter
		Mayhem
		Larceny of money or other property

- I understand that my caregiver registration 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: _____

Michigan Medical Marihuana Registry **Caregiver Attestation**

All fields below must be completed.

PRIMARY CAREGIVER 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. I declare that I am willing and able to serve as the primary caregiver for the below signed patient.

Signature of Caregiver: X _____ Date: _____

APPLICANT/PATIENT DECLARATION:

I declare that I am designating the above signed individual to be my caregiver. I have included this caregiver's name and information in Section B: Primary Caregiver on the enclosed application or change form. I have included a copy of this caregiver's Michigan driver license or Michigan state ID (OR his/her photo ID and Michigan voter registration) and this completed Caregiver Attestation.

Signature of Applicant/Patient: X _____ Date: _____

To ensure this attestation is complete, the caregiver 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 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?..... YES
(if applicable)
6. On page 2, did the caregiver and patient sign in the appropriate designated areas?..... YES
7. Provide this Attestation to the applicant/patient to submit to the MMP with the appropriate application or change form