*How did you hear about us?):*_____

*Is your Arizona Medical Marijuana Card currently active? (Circle) Yes **or** No **or** I am a first time patient*

Arizona Medical Marijuana Card Application Patient Information

(Attention: it is important for your information to be legible and accurate. All information will transfer to your state application. Errors can delay or interrupt your card process. Thank you!)

First name: _____ Middle (optional):_____

Last:_____

Date of Birth: _____ Phone:_____ Gender:

(Circle) Male or Female

Physical Address

Street: _____

City: _____ St:_____ Zip Code: _____

Mailing Address

(Leave this section blank if it is the same as your physical address)

Street: _____

City: _____ St:_____ Zip Code: _____

Emergency Contact: _____ # _____

Contact email provided to AZDHS

Please note that Your DIGITAL MMJ CARD and **time sensitive** information will be sent to this email including emails notifying the applicant that the application has been approved and/or if there are deficiencies that need to be corrected. **WE WILL CORRECT ANY APPLICATIONS THAT NEED CORRECTION, PLEASE DO NOT ATTEMPT TO MAKE CORRECTIONS.**

Natural Healing Care Center also receives the same State emails as the patients, and will fix all errors sent back from the state. ***PLEASE DO NOT ATTEMPT TO CORRECT ON YOUR OWN*

(2) Would you like to request **cultivation (growing) rights?** **Yes** or **No**
(Patients must live 25 miles away from an operating dispensary)

(3) Are you eligible for **SNAP assistance(food stamp)?** If proper documentation is provided, your application fee will be reduced from $150 to $75 **Yes** or **No**

(4) Will you need a Certified Medical Marijuana Caregiver? **Yes** or **No** (if no, skip to the signature line)

If yes, please fill out the **Caregiver's info:**

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ Zip: _____

If you are eligible to cultivate (grow) marijuana, are you giving your cultivation rights to your caregiver? ***Yes*** *or* ***No***

I have read and agree to the terms and conditions of Natural Healing Care Center and Arizona Department of Health Services.

_____ _____

Signature of Patient (or patient rep) Date

_____

Printed name of Patient (or patient rep)