

Michigan Medical Marihuana Program Application Instructions and Checklist

(517) 284-6400 | www.michigan.gov/mmp

Instructions for applying to the Michigan Medical Marihuana Program

Instructions

- 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
- **Make checks or money orders payable to: State of Michigan-MMMP**
- This application is for a person who is 18 years of age or older and a resident of Michigan.
- Please type or print legibly when completing the application.
- The original signed Application Form and Physician Certification Form must be submitted to the MMMP. Make sure to keep copies 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).
- Patient Fee: \$60**
- Caregiver Fee: \$25**
- 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.



Michigan Medical Marihuana Program
Application Form for Registry Identification Card

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For Official Use Only

MMP 3501 (Rev. 1/15)

- \$60 Patient (with no caregiver) Fee Received
- \$85 Patient (with caregiver) Fee Received

Section A: Patient Information (REQUIRED) as it appears on your identification

| | | | |
|--|-----------------------|---|----------------------------------|
| 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) P | | 5. MI Driver's License# or MI ID Card # | 6. Date of Birth (MM/DD/YYYY) |
| 7a. Mailing Address | | 7b. Apartment/Suite/Lot # | |
| 8. City | 9. State MI | 10. Zip Code | |
| 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) C | | 18. MI Driver's License# or MI ID Card # | 19. Date of Birth (MM/DD/YYYY) |
| 20a. Mailing Address | | 20b. Apartment/Suite/Lot # | |
| 21. City | 22. State MI | 23. Zip Code | |
| 24. Email Address (If provided, you agree to receive email correspondence from MMMP) | | 25. Telephone Number | |

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

Section D: Caregiver Patient Signature & Date (Required)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 et seq.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

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

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