Michigan Medical Marijuana Program

Application/Renewal Instructions and Checklist

www.michigan.gov/mmp

Application for Registry Identification Card

(517) 284-6400

Apply or Renew Online at www.michigan.gov/mmp

- You must be a patient without a caregiver (or remove caregiver upon renewing) and create a secure online account.
- You must have an in-person medical evaluation from an active Michigan physician before your application will be approved.
- Only online applicants will receive their approval or denial through email. An approval email will serve as a temporary card.

Instructions for Paper Application

- This application is for a person who is 18 years of age or older and a resident of Michigan.
- Type or print legibly when completing the application.
- The original signed Application Form and Physician Certification Form must be submitted to the MMMP.
- Keep a copy of all documents submitted for your records.
- All documents must be signed within six months from the date they are received.
- A renewal application will only be accepted within 90 days prior to the card's expiration date.
- Make checks or money orders payable to: **State of Michigan-MMMP.**
- Do not include other forms, fees, or documentation in the envelope.
- Mail only one complete application and **all** required documentation (see below) in **one** envelope to:

Michigan Medical Marijuana Program
P.O. Box 30083
Lansing, MI 48909

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 his or her proof of Michigan Residency (see below). If your MDPOA has specific conditions that must be met before it becomes activated, you must submit proof those conditions (e.g. proof the patient is incapacitated) have been met.

☐ Application Fee: $40

☐ If designating a caregiver, include:

- A copy of caregiver's valid state-issued driver license or personal identification card.

☐ Proof of Michigan Residency (Valid Michigan driver license, personal identification card, or signed voter registration)

- Copies must be clear and legible.
- A copy of a voter registration without a signature is not valid. If a patient submits a voter registration, you must include additional proof of valid identity for verification purposes (i.e., government-issued document that includes your name and date of birth)

☐ Physician Certification Form

- A Physician Certification Form must be completed and signed by a medical doctor or doctor of osteopathic medicine and surgery who holds a current license to practice in 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
$40 Fee Required

Application Form for Registry Identification Card

To Apply or Renew Online Visit our website www.michigan.gov/mmp

DO NOT MAIL MORE THAN ONE APPLICATION PER ENVELOPE

Section A: Patient Information (NAME AS IT APPEARS ON ID) *(REQUIRED)*

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

4. Patient Registry ID Card Number (For Renewals Only)	5. Date of Birth (MM/DD/YYYY)

6a. Mailing Address	6b. Apartment/Suite/Lot #

7. City	8. State	9. Zip Code
	MI	

10. Telephone Number (Optional)

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

11. 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 (NAME AS IT APPEARS ON ID) *(If the patient is designating a caregiver)*

12. Legal First Name	13. Middle Initial	14a. Legal Last Name	14b. Suffix (Jr., Sr., etc.)

15. Caregiver Registry ID Card Number (For Renewals Only)	16. Date of Birth (MM/DD/YYYY)

17a. Mailing Address	17b. Apartment/Suite/Lot #

18. City	19. State	20. Zip Code

21. Telephone Number (Optional)

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

Section D: Patient /Caregiver 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*.) and associated administrative rules. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the Michigan Secretary of State's office to forward my photograph to the Michigan Medical Marijuana Program to be printed on my registry identification card. I authorize the release of my protected health information, which includes the information contained in the form completed by my certifying physician, to the Michigan Medical Marijuana Program.

Signature of Patient: _____ **Date:** _____

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*.) and associated administrative rules. I agree to serve as the patient's primary caregiver, am at least 21 years old, have no convictions that disqualify me from serving as a primary caregiver, and authorize the department to use the information provided in this application to perform a criminal background check. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the Michigan Secretary of State's office to forward my photograph to the Michigan Medical Marijuana Program to be printed on my registry identification card.

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

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Physician Certification Form

This certification must be completed and signed by a medical doctor or doctor of osteopathic medicine and surgery who holds an active license to practice in the State of Michigan.

Section A: Certifying Physician Information (AS IT APPEARS ON MEDICAL LICENSE) *(REQUIRED)*

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

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

5. City	6. State	7. Zip Code	8. Telephone Number

9. Michigan Physician License Number **(enter only 10 digits)**

☐ **M.D.** _ _ _ _ _ _ _ _ _ _ ☐ **D.O.** _ _ _ _ _ _ _ _ _ _

Section B: Patient Information (NAME AS IT APPEARS ON ID) *(REQUIRED)*

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

13. Date of Birth (MM/DD/YYYY)

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

This patient has been diagnosed with the following debilitating medical condition(s):
(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 ☐ 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)	☐ Post Traumatic Stress Disorder ☐ Obsessive Compulsive Disorder ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Spinal Cord Injury ☐ Colitis ☐ Inflammatory Bowel Disease ☐ Ulcerative Colitis ☐ Parkinson's Disease ☐ Tourette's Syndrome ☐ Autism ☐ Chronic Pain ☐ Cerebral Palsy

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 and associated administrative rules and have a bona fide physician-patient relationship with this patient. 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 marijuana to treat or alleviate the debilitating medical condition identified above or symptoms associated with that condition.

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