Michigan Medical Marijuana Program

Application for Registry Identification Card

FOR MINOR APPLICANTS ONLY

Instructions

- This application is for a person who is under 18 years of age and a resident of Michigan.
- Type or print legibly when completing the application.
- The original signed Application Form and both Physician Certification Forms 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 of the card's expiration date.
- Make check or money order 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

☐ **Minor Application Form for Registry Identification Card**

- Any use of white-out on or alterations to the Minor Application Form will result in the denial of your application.

☐ **Application Fee: $40**

- Make checks or money orders payable to: State of Michigan-MMMP.

☐ **Proof of Michigan Residency**

- Parent or legal guardian must a submit copy of his or her valid Michigan driver license or personal identification card.
- If the minor patient has a valid Michigan driver license or personal identification card, please submit a copy with the application.
- The copies must be clear and legible.

☐ **Copy of proof of parentage or legal guardianship** ((i.e.,birth certificate, court order, etc.) If their has been a name change, please include proof of name change (i.e. marriage license, divorce decree, etc.))

☐ **Two Physician Certification Forms**

- Two Physician Certification Forms must be completed and signed by two separate physicians. Each physician must be 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 either Physician Certification Form will result in the denial of your application.

Michigan Medical Marijuana Program
www.michigan.gov/mmp
(517) 284-6400

For Official Use Only
$40 Fee Required

Application Form for Registry Identification Card
MINOR APPLICANTS ONLY

Section A: Patient Information (NAME AS IT APPEARS ON ID OR PROOF OF PARENTAGE) ***(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)
P	

6a. Mailing Address

6b. Apartment/Suite/Lot #

7. City	8. State	9. Zip Code
	MI	

10. Telephone Number (optional)

The parent or legal guardian listed in Section C must serve as the patient's caregiver and possess the minor patient's medical marijuana plants.

Section C: Parent or Legal Guardian Information (NAME AS IT APPEARS ON ID) ***(REQUIRED)***

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

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

17a. Mailing Address

17b. Apartment/Suite/Lot #

18. City	19. State	20. Zip Code
	MI	

21. Telephone Number (optional)

22. Other Names Used by Parent or Legal Guardian (Nicknames, maiden names etc. Use a separate piece of paper if you need more space.)

Section D: Parent/Legal Guardian 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 attest that I am at least 21 years old, have no felony 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 release of the above named patient's protected health information, which includes the information contained in the form completed by my certifying physician, to the Michigan Medical Marijuana Program. 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 Parent/Legal Guardian: _____ **Date:** _____

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Declaration of Person Responsible for MINOR Patient

DECLARATION BY PARENT OR LEGAL GUARDIAN *(REQUIRED)*

To be signed and completed by patient's parent or legal guardian

This Declaration of Person Responsible form must be completed and submitted with the MINOR application packet. Only the parent or legal guardian can serve as the primary caregiver for a minor patient. A copy of proof of parentage or legal guardianship (i.e. birth certificate or court order, etc.) must be submitted with a Minor Application or the application will be denied.

I declare each of the below statements is true and accurate:

- The patient's physicians have explained to the patient and me the potential risks and benefits of the medical use of marijuana.
- I consent to the patient's medical use of marijuana.
- I agree to serve as the patient's designated caregiver.
- I agree to control the acquisition, dosage, and frequency of the medical use of the marijuana by the patient.

Section E: Parent or Legal Guardian Declaration: *(REQUIRED)*

I attest the information 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.

Signature of Parent/Legal Guardian: X_____ Date:_____

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Physician Certification Form #1 for Minor Patient

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 (NAME & LICENSE NUMBER 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:** _____

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Physician Certification Form #2 for Minor Patient

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 (NAME & LICENSE NUMBER 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:** _____