LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Application for Registry Identification Card

Instructions

- 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 one year from the date they are received.
- A renewal application will only be accepted within 60 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 Marihuana 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.

Patient Fee: $60

If designating a caregiver, include:

- $25 caregiver fee
- 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 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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Michigan Medical Marihuana Program
www.michigan.gov/mmp
(517) 284-6400

For Official Use Only
$60 Patient (with no caregiver) Fee Received
$85 Patient (with caregiver) Fee Received

Application Form for Registry Identification Card

DO NOT MAIL MORE THAN ONE APPLICATION PER ENVELOPE

Section A: Patient Information (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 Marihuana 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 (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)	17. Gender (used for conviction history only) ☐Male ☐ Female

18a. Mailing Address	18b. Apartment/Suite/Lot #

19. 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.

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.

Signature of Caregiver: ______________________ **Date:** __________