LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

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

For Official Use Only
☐ $35 Fee Received

Add or Change Caregiver Form

This form is for active registered PATIENTS who are adding or changing their caregiver. You may also change your address at this time. If a new address is listed, we'll update your address on all active registry cards. Only one address is allowed per person in the program.

INSTRUCTIONS

1. Complete Sections A, B, and C and include the following:
   - Patient: Include a copy of patient's valid Michigan driver license, personal identification card, or signed voter registration. If a patient submits a voter registration, he or she must include additional proof of identity for verification purposes (i.e., government-issued document that includes your name and date of birth).
   - Caregiver: Include copy of new caregiver's valid state-issued driver license or personal identification card.
2. Sign and date the form.
3. Include check or money order for $35 made payable to: **State of Michigan-MMMP.**
4. Make a copy of the completed form and all required documentation for your records.
5. Do not include any other forms, fees, or documentation in the envelope.
6. Mail completed form and **all** required documentation in **one** envelope to:

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

☐ **Section A: Patient Information (As it appears on your current registry ID card) *(REQUIRED)***

Patient Registry ID Card Number (If known)	Date of Birth	Telephone Number	
Legal First Name	Middle Initial	Legal Last Name	Suffix (Jr., Sr., etc.)
Mailing Address (If your address has changed, provide your new address)		Apartment/Suite/Lot #	
City	State	Zip Code	

☐ **Section B: New Caregiver Information *(REQUIRED)***

Legal First Name	Middle Initial	Legal Last Name	Suffix (Jr., Sr., etc.)
Date of Birth	Aliases/Maiden Name	Gender (used for conviction history) ☐ Male ☐ Female	
Mailing Address	Apartment/Suite/Lot #		
City	State	Zip Code	

☐ **Section C: Plant Possession *(REQUIRED)***

Plant possession: You must select one box. **Select Only One:** ☐ I will possess the plants ☐ My caregiver will possess the plants

Patient Signature & Declaration *(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: X _____ **Date:** _____

Caregiver Signature & Declaration *(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. Further, I agree to serve as the patient's primary caregiver, have no convictions that will disqualify me from serving as a primary caregiver, and authorize the department to use the information provided 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: X _____ **Date:** _____