



Colorado Department
of Public Health
and Environment

Medical Marijuana Registry



CHANGE OF CARE-GIVER/MEDICAL MARIJUANA CENTER

INSTRUCTIONS:

When there has been a change of care-giver of a patient who has qualified for a registry identification card, that **patient must** notify the state health agency of any such change within **ten (10) days**. Please complete all required information in **blue ink**, sign, and date in front of notary, and have notarized. **Whiteout and cross-outs will void this form**. Mail this form with a legible copy of the patient's and care-giver's photo ID to:

Colorado Department of Public Health and Environment
Medical Marijuana Registry
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530

Incomplete forms or forms without ID, will be returned to the applicant. You may contact the Registry at 303-692-2184.

APPLICANT ID Required	1. Last Name <i>(as it appears on your ID)</i>		2. First Name <i>(as it appears on your ID)</i>		3. Middle Initial	
	4. Mailing Address		5. City		6. Zip Code	7. County CO
	8. Social Security Number _ _ - - - -		9. Date of Birth / /		10. Telephone Number	
					11. e-mail Address*	
12. Gender M <input type="checkbox"/> F <input type="checkbox"/>		13. Are you homebound? Yes <input type="checkbox"/> No <input type="checkbox"/>				
		14. Provider of medical marijuana: Select one of the following that best describes your intended source of medical marijuana: <input type="checkbox"/> Self (skip the "Provider" section below) <input type="checkbox"/> Care-giver (Required: enter name and address below) <input type="checkbox"/> Medical Marijuana Center (Required: enter name and address below) <input type="checkbox"/> Self and Care-giver (Required: enter name and address below) <input type="checkbox"/> Self and Medical Marijuana Center (Required: enter name and address below)				
PROVIDER	Medical Marijuana Center					
	15a. Name of Medical Marijuana Center (skip this field if using a care-giver)			15c. City		15d. State
	15b. Mailing Address of Medical Marijuana Center			15e. Zip Code		15f. Telephone Number
Care-Giver (ID required)						
16a. Last Name of Care-Giver <i>(as it appears on ID)</i>		16b. First Name <i>(as it appears on ID)</i>		16c. Middle Initial		
16d. Mailing Address		16e. City		16f. State	16g. Zip Code	
16h. Date of Birth / /		16i. Telephone Number		16j. Alternate Number		

WARNING! THE USE, POSSESSION, DISTRIBUTION, AND MANUFACTURE OF MARIJUANA REMAINS A FEDERAL CRIME IN COLORADO, AND POSSESSION OF A REGISTRATION CARD PROVIDES NO PROTECTION WHATSOEVER AGAINST FEDERAL CRIMINAL PROSECUTION.

I hereby certify that the above information is correct and complete.

17. Applicant's Signature: 	18. Date Signed:
--------------------------------	------------------

The Applicant's Signature has been subscribed and affirmed before me in the county of _____, State of Colorado, this _____ day of _____, 20_____.

(Notary's Official Signature)

(Commission expiration date)


AFFIX NOTARY SEAL

Rev. July 2010

* I consent for communications from the Registry via e-mail

CHANGE OF CARE-GIVER (backside)

PATIENT'S AND CAREGIVER'S PROOF OF IDENTITY AND PROOF OF RESIDENCY IN COLORADO

At least 1 of the following	Or at least 2 of the following
Colorado Driver's License	Minimum of 1 from the group of ID's below -
Colorado ID	Out of State Driver's License
Temporary Colorado Driver's License	Out of State ID
Temporary Colorado ID	Passport, Military ID, Tribal ID
 Colorado Department of Public Health and Environment	And a Minimum of 1 from the group below -
	Work Identification/paycheck stub/W-2
	Utility bill, medical/insurance bill or cable bill <i>The above items must show a Colorado residence</i>

All Documents must be currently valid!

At least one of these documents must show the applicant's date of birth.