Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
Email: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

Application Instructions

Colorado Medical Marijuana Registration Cards are available **only** for Colorado residents being treated for an active, debilitating medical condition. To apply for a registration card, please submit a complete, accurate application packet as described below. If your application is incomplete or incorrect, the entire packet will be returned to you. If you make a mistake on a form, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**

A complete application packet includes:

1. An Application for Registration Card completed by you, signed and notarized.
2. A Physician Certification completed by your doctor.
3. A copy of your Colorado ID. If you do not have a Colorado ID, submit proof of identity and Colorado residency.
4. A copy of your caregiver's valid ID, if a caregiver is selected.
5. A form of payment or a Request for Fee Waiver/Tax Exempt Status form and supporting materials.

1. Medical Marijuana Registry Application

a. Please complete the entire application. Write or type clearly and neatly.
b. You may select to have a caregiver or a Medical Marijuana Center. It is not required to have either.
c. If you are under age 18 or homebound, you may choose both a caregiver and a Medical Marijuana Center.
d. Complete the physician information. Make sure the physician information on the Medical Marijuana Registry Application matches the information provided by your doctor on the Physician Certification.
e. You must sign and date this form in front of a Colorado notary. The date of your signature and the notary's signature must be the same.
f. The form cannot be notarized by the patient, the caregiver, the physician or the person who signs the payment.

2. Physician Certification

a. Your physician must complete and sign the Physician Certification.
b. The signing physician must be an MD or DO with an active Colorado medical license. Physicians with conditions or restrictions on their licenses, or out-of-state licenses, are not accepted.
c. Send in your application packet as soon as possible after the physician signs the Physician Certification. The Registry must receive your complete, correct application packet within 60 days of the physician's signature. **Application packets with Physician Certifications more than 60 days old are rejected.**

3. Proof of Identity and Residency

a. Medical Marijuana Registration cards are available only to Colorado residents. You must provide proof of your identity and residency. Damaged, expired or tampered IDs are not valid.
b. If you select a caregiver, include a copy of the caregiver's photo ID with the application packet.

<table>
<tr><th colspan="2">PROOF OF IDENTITY AND COLORADO RESIDENCY</th></tr>
<tr><td>One (1) of the following:
• Colorado Driver's License
• Colorado ID
• Temporary Colorado Driver's License
• Temporary Colorado ID</td><td>Or two (2) of the following:
Minimum of one (1) from the group of IDs below -
• Out of State Driver's License
• Out of State ID
• Passport, Military ID (copy of front and back), Tribal ID
And a minimum of one (1) from the group below -
• Proof of Colorado Employment (paycheck stub/W-2)
• Copy of a utility, medical, or cable bill. (The mailing address on all bills must match address on application. For utility and cable bills, the service address must be in Colorado.)</td></tr>
<tr><td colspan="2">i. All documents must be currently valid when received at the Registry. Broken, expired, or tampered IDs are not valid.
ii. Proof of residency materials must be current, within 60 days of the date the Registry receives your paperwork.
iii. At least one (1) of these documents must show the patient's date of birth</td></tr>
</table>

Colorado Department of Public Health and Environment

4. **Non-refundable $90 application fee or Request for Fee Waiver**
   a. **To pay $90 application fee:** Make check or money order payable to CDPHE. We do not accept temporary checks. Please write the patient's name on the payment. Make sure the form of payment is signed. The notary cannot sign the form of payment. The date of payment must be less than one (1) year old when received at the Registry.
   b. **To request fee waiver:** You must submit a Fee Waiver Request (form #MMR1010) with your application packet. You may qualify for a fee waiver if you meet at least one of the following criteria:
      i. You currently receive Supplemental Security Income;
      ii. You currently receive Food Stamps; or
      iii. Your household income is at 185% of the Federal Poverty Level or less. The chart below indicates the annual household incomes, adjusted for family size, that qualify for a fee waiver.

Household incomes at 185% of 2011 Federal Poverty Guidelines*
Source: Federal Register, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638

# in Family	Annual Income
1	$ 20,146.50
2	$ 27,213.50
3	$ 34,280.50
4	$ 41,347.50
5	$ 48,414.50
6	$ 55,481.50
7	$ 62,548.50
8	$ 69,615.50
Each additional	$ 7,067.00

* Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)

5. **Application packets must be sent separately.** Only one application packet and check/money order per envelope. If sending by certified mail, certify each envelope separately.

6. **Submit all items by mail or deliver to the Registry's drop-box.** The Registry does not accept forms by fax or email.

Mail To:
Colorado Dept. of Public Health & Environment
HSV-MMR
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, Southeast Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

For more information, please visit: www.cdphe.state.co.us/hs/medicalmarijuana.
The Registry is not affiliated with any privately operated club, organization, or dispensary.

Colorado Department of Public Health and Environment

Application Instructions

Application Packet Checklist:

- ❑ The Application is complete and accurate.
- ❑ The Application was signed and dated by you and a Colorado notary.
- ❑ The dates of your signature and the notary's signature match.
- ❑ The Physician Certification is complete and accurate.
- ❑ The date of the Physician's signature is current. Mail your application packet as soon as possible after your physician signs the Physician Certification
- ❑ There are no areas on any of the forms where information has been written over, crossed out or white-out was used.
- ❑ You have included a clear copy of your valid Colorado ID.
- ❑ If you do not have a Colorado ID, you have included a clear copy of your ID and proof of residency.
- ❑ If included, the address on your proof of residency paperwork matches the address on the Application.
- ❑ If included, all copies of utility or cable bills show both the "mail to" address and the "service" address. Both addresses are in Colorado.
- ❑ You have made copies of all the documents you are sending to the Registry.
- ❑ You have included a form of payment or the Request for Fee Waiver/Tax-Exempt Status form.
- ❑ Submit your application packet for yourself. Do not allow anyone else to submit the paperwork for you.
- ❑ Send your application packet by certified mail to have proof of submission. Keep the mail receipt.
- ❑ Check our website (www.cdphe.state.co.us/hs/medicalmarijuana) for a time estimate for processing applications.

Questions can be sent by email to medical.marijuana@state.co.us or by phone at 303-692-2184.

Application Review Process:

1. **Initial Review:** The Registry reviews all applications against criteria described in the Application Instructions. The nonrefundable application fee, if included in the application packet, is cashed.
2. **Approved Application:** If an application packet is complete and has all supporting materials, a card is mailed to the patient.
3. **Rejected Application:** If an application packet is inaccurate or incomplete, the Registry returns the entire application packet to the patient. A rejection letter is sent with the application packet detailing corrections that are needed. With each rejection, patients are given 60 days to make corrections without paying additional application fees. Patients are given two (2) opportunities to re-submit their application packet with corrections to the Registry.
4. **Approved Corrections:** When a corrected application packet is returned, it is again reviewed for accuracy and completeness. If the application packet is correct, a card is mailed to the patient.
5. **Corrections Beyond 60-Days**: Patients who do not submit corrections within the 60-day window must submit a new application packet and an additional $90 application fee.
6. **Denial:** The application is denied after the patient has submitted inaccurate or incomplete application information three times (the original application plus two correction attempts). The patient will have to wait six (6) months before re-applying for a Medical Marijuana Registration card, if the application is denied.
7. **Appeals:** If an application is denied, or the Registry suspends or revokes the patient's current registration card, a notice will be sent to the patient with details regarding the reason for denial, suspension or revocation. If the patient disagrees with a final decision from the Registry, the patient may send a letter to the Registry requesting an appeals hearing. The request for hearing must be received by the Registry within thirty (30) calendar days from the date of the postmark on the notice.

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Application for Registration Card

☐ **New:** This is the first time I have applied in Colorado. ☐ **Renewal:** I have been on the Colorado Registry before.

STAFF ONLY

Homebound ❑ Yes ❑ No

Tax Exempt ❑ Yes ❑ No

EPU Approval ❑ Yes ❑ No

QA Approval ❑ Yes ❑ No

IU Approval/ Card Printed ❑ Yes ❑ No

Corrections:

Section A: Patient Information (Required)

The name on the form must match the legal name on your photo ID.

1. Social Security Number / /				
2. Last Name		3. First Name		4. Middle Initial
5. Mailing Address (including Apartment or Suite #)				6. City
State **CO**	7. Zip Code	8. County	9. Date of Birth / /	10. Telephone Number ( ) -
11. E-mail Address (optional)*				12. Gender ☐ Male ☐Female

* By providing your email address, you agree to receive communication from the Registry by e-mail.

Section B: Caregiver Information (Optional)

A copy of the caregiver's photo ID is required. The name on the form must match the legal name on the caregiver's ID. Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.

13. Caregiver's Last Name (as on ID)		14. Caregiver's First Name (as on ID)		15. Middle Initial
16. Caregiver's Mailing Address (including Apartment or Suite #)				
17. City	18. State	19. Zip Code	20. Date of Birth / /	21. Telephone Number ( ) -

Section C: Medical Marijuana Center Information (Optional)

Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.

22. Name of Medical Marijuana Center			
23. Mailing Address of the Medical Marijuana Center			
24. City	State **CO**	25. Zip Code	26. Telephone Number ( ) -

Section D: Physician Information (Required)

Physician name must match the name on the Physician Certification submitted with this application packet.

27. Physician's Last Name	28. Physician's First Name

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

29. Patient's Signature: ▶	30. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by

____ in _________________________ County, Colorado on this
(Name of signatory printed by notary) (County name)

_________day of _____________, 20____.
(Day) (Month)

____
(Notary's official signature)

____
(Commission expiration date)

AFFIX NOTARY SEAL

Physician Certification Instructions

1. Complete the entire form, sign and date.
2. If you make a mistake on this form, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**
3. Please keep a copy of the form in the patient's medical record. To avoid fraud, the Registry verifies all physician signatures. You will receive a verification letter for patients in the months the Registry receives Physician Certifications with your signature.
4. Please do not fax or e-mail the form to the Registry. The patient must submit the Physician Certification along with his or her complete Medical Marijuana Registry application packet.
5. This does not constitute a prescription for marijuana.
6. To sign the form, you must be an MD or DO with an active Colorado medical license. Physicians with condition or restrictions on their licenses, or out-of-state licenses, are not accepted.
7. A copy of your current DEA certification must be on file in the Registry's office. If you have not already provided this, please fax a copy to 303-758-5182. If your DEA is not on file when we receive your patient's paperwork, it will be rejected.
8. Encourage patients to submit their application packets as soon as possible after you sign the Physician Certification. **The Registry rejects Physician Certifications that are more than 60 days old.**
9. The Registry has included in the application packet, for your review, **"Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights."** For a link to the complete Board of Health rules, please visit our website www.cdphe.state.co.us/hs/medicalmarijuana.
10. You may contact the Registry at medical.marijuana@state.co.us or (303) 692-2184, if you have any questions.

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Physician Certification

STAFF ONLY

EPU Approval ❑ Yes ❑ No

Corrections:

Patient Information

1. Last Name	2. First Name	3. Middle Initial	4. Date of Birth: / /

5. What is the date of physical examination for the purpose of the medical marijuana recommendation? (mm/dd/yyyy) ____/____/_____

6. How many times during the previous 12 months have you seen this patient?

7. Are you available to provide follow-up care for this patient? ☐Yes ☐No

8. What is the date by which the patient should schedule a follow-up care visit? (mm/dd/yyyy)_____/____/_____

9. In your opinion, is this patient homebound? ☐ Yes ☐ No

Physician Information

10. License Number DR -	11. Last Name	12. First Name	13. Middle Initial

14. Mailing Address

15. City	16. State	17. Zip Code

18. Telephone Number ( ) -	19. Fax Number ( ) -	20. Email Address (optional)

21. DEA Certification: The Registry requires a copy of your current DEA certification for their files. If you have not already provided this, **FAX a copy to 303-758-5182 to prevent delays in processing this application.**

Physician's Statement

22. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic, debilitating medical condition.

☐ a. Cancer ☐ b. Glaucoma ☐ c. HIV or AIDS positive

or The patient has a chronic or debilitating disease or medical condition that produces one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

☐ d. Cachexia ☐ e. Severe nausea ☐ f. Seizures ☐ g. Persistent muscle spasms

☐ h. Severe pain (The etiology is required by law whenever severe pain is selected.)

Etiology:______________________________**or** ☐ Etiology unknown.

23. Please indicate the number of plants and ounces of marijuana you recommend for this patient.

☐ Standard Amount: 6 plants/2 ounces

☐ Increased Amount: _____ plants/_____ ounces

24. Comments: (If no comments, the Registry recommends crossing through this area to prevent comments after your signature.) ____

____

____

____

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition. I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

25. Physician's Signature ►	26. Date (mm/dd/yyyy)

Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights

A. **Physician requirements.** A physician who certifies a debilitating medical condition for an applicant to the medical marijuana program shall comply with all of the following requirements:

1. **Colorado license to practice medicine.** The physician shall have a valid, unrestricted Colorado license to practice medicine, which license is in good standing.

   a. For the purposes of certifying a debilitating medical condition of an applicant and recommending the use of medical marijuana for the medical marijuana program, "in good standing" means:

      i. The physician holds a doctor of medicine or doctor of osteopathic medicine degree from an accredited medical school;

      ii. The physician holds a valid license to practice medicine in Colorado that is not restricted or conditioned, unless the physician has received written confirmation from the Colorado medical board that the physician's scope of practice does not preclude recommending medical marijuana; and

      iii. The physician has a valid and unrestricted United States Department of Justice federal drug enforcement administration controlled substances registration.

2. **Bona fide physician patient relationship.** A physician who meets the requirements in subsection A.1 of this Regulation 8 and who has a bona fide physician-patient relationship with a particular patient may certify to the state health agency that the patient has a debilitating medical condition and that the patient may benefit from the use of medical marijuana. If the physician certifies that the patient would benefit from the use of medical marijuana based on a chronic or debilitating disease or medical condition, the physician shall specify the chronic or debilitating disease or medical condition and, if known, the cause or source of the chronic or debilitating disease or medical condition.

   a. "Bona fide physician-patient relationship", for purposes of the medical marijuana program, means:

      i. A physician and a patient have a treatment or counseling relationship, in the course of which the physician has completed a full assessment of the patient's medical history and current medical condition, including an appropriate personal physical examination;

      ii. The physician has consulted with the patient with respect to the patient's debilitating medical condition before the patient applies for a registry identification card; and

      iii. The physician is available to or offers to provide follow-up care and treatment to the patient, including but not limited to patient examinations, to determine the efficacy of the use of medical marijuana as a treatment of the patient's debilitating medical condition.

   b. A physician making medical marijuana recommendations shall comply with generally accepted standards of medical practice, the provisions of the medical practice act, § 12-36-101 *et seq.* , C.R.S, and all Colorado Medical Board rules.

   c. The "appropriate personal physical examination" required by paragraph A.2.a.i of this Regulation 8 may not be performed by remote means, including telemedicine.

3. **Medical records.** The physician shall maintain a record-keeping system for all patients for whom the physician has recommended the medical use of marijuana. Pursuant to an investigation initiated by the Colorado medical board, the physician shall produce such medical records to the Colorado Medical Board after redacting any patient or primary caregiver identifying information.

4. **Financial prohibitions.** A physician shall not:

   a. Accept, solicit, or offer any form of pecuniary remuneration from or to a primary caregiver, distributor, or any other provider of medical marijuana;

   b. Offer a discount or any other thing of value to a patient who uses or agrees to use a particular primary caregiver, distributor, or other provider of medical marijuana to procure medical marijuana;

c. Examine a patient for purposes of diagnosing a debilitating medical condition at a location where medical marijuana is sold or distributed; or

d. Hold an economic interest in an enterprise that provides or distributes medical marijuana if the physician certifies the debilitating medical condition of a patient for participation in the medical marijuana program.

B. **Reasonable cause for referral of a physician to the Colorado Medical Board.** For reasonable cause, the department may refer a physician who has certified a debilitating medical condition of an applicant to the medical marijuana registry to the Colorado Medical Board for potential violations of sub-paragraphs 1, 2, and 3 of paragraph A of this rule.

C. **Reasonable cause for department sanctions concerning physicians.** For reasonable cause, the department may sanction a physician who certifies a debilitating medical condition for an applicant to the medical marijuana registry for violations of paragraph A.4 of this rule. Reasonable cause shall include, but not be limited to:

1. The physician is housed onsite and/or conducts patient evaluations for purposes of the medical marijuana program at a location where medical marijuana is sold or distributed, such as a medical marijuana center, optional grow site, medically infused products manufacturer, by a primary caregiver, or other distributor of medical marijuana.
2. A physician who holds an economic interest in an entity that provides or distributes medical marijuana, such as a medical marijuana center, an infused products manufacturer, an optional grow site, a primary caregiver, or other distributor of medical marijuana.
3. The physician accepts, offers or solicits any form of pecuniary remuneration from or to a primary caregiver, medical marijuana center, optional grow site, medically infused product manufacturer, or any other distributor of medical marijuana.
4. The physician offers a discount or any other thing of value, including but not limited to a coupon for reduced-price medical marijuana or a reduced fee for physician services, to a patient who agrees to use a particular medical marijuana center, primary caregiver, or other distributor of medical marijuana.

D. **Sanctions.** For reasonable cause, the department may propose any of the following sanctions against a physician:

1. Revocation of the physician's ability to certify a debilitating medical condition and recommend medical marijuana for an applicant to the medical marijuana registry; or
2. Summary suspension of the physician's ability to certify a debilitating medical condition or recommend medical marijuana for an applicant to the medical marijuana registry when the department reasonably and objectively believes that a physician has deliberately and willfully violated section 14 of article xviii of the state constitution or § 25-1.5-106, C.R.S. and the public health, safety and welfare imperatively requires emergency action.

E. **Appeals.** If the department proposes to sanction a physician pursuant to paragraph c of this rule, the department shall provide the physician with notice of the grounds for the sanction and shall inform the physician of the physician's right to request a hearing.

1. A request for hearing shall be submitted to the department in writing within thirty (30) calendar days from the date of the postmark on the notice.
2. If a hearing is requested, the physician shall file an answer within thirty (30) calendar days from the date of the postmark on the notice.
3. If a request for a hearing is made, the hearing shall be conducted in accordance with the state administrative procedures act, § 24-4-101 et seq. , C.R.S.
4. If the physician does not request a hearing in writing within thirty (30) calendar days from the date of the notice, the physician is deemed to have waived the opportunity for a hearing.