



Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184

E-mail: medical.marijuana@state.co.us • Website: www.cdph.state.co.us/hs/medicalmarijuana

Medical Marijuana Registry Card Application for Patients Under 18 Years of Age

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 for patients under 18 years of age includes:

1. An Application for Registration Card completed by you, signed and notarized.
2. A Parental Consent Form completed by all parents or legal guardians living in Colorado. If a parent/legal guardian does not reside in Colorado, proof of identity and out-of-state residency must be provided.
3. Two Physician Certifications completed by two separate doctors.
4. A copy of the patient's certified birth certificate or a certified legal guardianship order.
5. A copy of the patient's valid Colorado ID.
6. A copy of both parents/guardians' valid Colorado IDs. If the Primary Parent/Caregiver does not have a Colorado ID, that parent must submit proof of identity and residency.
7. A form of payment or a Request for Fee Waiver/Tax Exempt Status form and supporting materials.

1. Application for Registration Card

- a. Please complete the entire application. Write or type clearly and neatly.
- b. The Primary Parent is listed as the caregiver. You may also choose to list a Medical Marijuana Center.
- c. 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.
- d. 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.
- e. The form cannot be notarized by the patient, the caregiver, the physician or the person who signs the payment.

2. Parental Consent Form

- a. One parent or legal guardian must be listed as the "Primary Parent/Guardian." The Primary Parent/Guardian is listed on the patient's card as the Primary Caregiver. The Primary Parent/Guardian must be a Colorado resident.
- b. All parents or legal guardians living in Colorado must complete the Parental Consent form.
- c. All parents or legal guardians living in Colorado must sign and date this form in front of a Colorado notary. The date of parent/guardian signatures and the notary's signature must be the same.
- d. The form cannot be notarized by the patient, the caregiver, the physician or the person who signs the payment.
- e. Parents who do not live in Colorado must submit proof of identity and out-of-state residency.

3. Physician Certification

- a. Patients under 18 years of age are required to have two Physician Certifications completed by two separate doctors.
- 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.

4. Patient's Proof of Identification and Parental/Guardian Relationship

- a. Include a copy of the patient's certified birth certificate or certified legal guardianship order. The certificate is used to prove relationship between parents(s)/legal guardians(s) and the patient.
- b. Include a copy of the patient's photo ID.
- c. Copies must be clear enough for the Registry to read.

5. Proof of Identity and Residency

- a. Medical Marijuana Registration cards are available only to Colorado residents. The patient and all parents/guardians living in Colorado must provide proof of identity and residency.
- b. All copies must be clear enough for the Registry to read.
- c. Damaged, expired or tampered IDs are not valid.



Application Instructions

PROOF OF IDENTITY AND COLORADO RESIDENCY

One (1) of the following:

- Colorado Driver’s License
- Colorado ID
- Temporary Colorado Driver’s License
- Temporary Colorado ID

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.)

- All documents must be currently valid when received at the Registry.
- Proof of residency materials must be current, within 60 days of the date the Registry receives your paperwork.
- At least one (1) of these documents must show the patient’s date of birth.

6. Non-refundable \$35 application fee or Request for Fee Waiver

The following application fee and fee waiver process are effective for applications received January 1, 2012 or later.

- To pay \$35 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.
- 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 your household income is at 185% of the Federal Poverty Level or less. The chart below shows 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)

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

Mail To:

Colorado Dept. of Public Health & Environment
Medical Marijuana Registry (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.**



Application Instructions

Application Packet Checklist:

- The Application is complete and accurate.
- The Application was signed and dated by you and a Colorado notary.
- The Parental Consent form is complete, accurate and notarized.
- The dates of your signature and the notary's signature match.
- The two Physician Certifications are complete and accurate.
- The Physicians signature dates are current, within 60 days. 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, readable copy of your valid Colorado ID.
- You have included a clear, readable copy of the Primary Parent/Guardian's Colorado ID.
- If you or your Primary Parent/Guardian do not have a Colorado ID, included a copy of the out-of-state 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 included a copy of your certified birth certificate or certified guardianship orders.
- You have made copies of all the documents you are sending to the Registry.
- 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 e-mail 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 \$35 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). If the application is denied, the patient will have to wait six (6) months before re-applying for a Medical Marijuana Registration card.
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.

For more information, please visit: www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.
The Registry is not affiliated with any privately operated club, organization, or dispensary.



Medical Marijuana Registry

Parental Consent Form Instructions

STAFF ONLY

EPU Approval
 Yes No

Corrections:

Section A: Patient (Photo ID and certified birth certificate /certificate of legal guardianship required.)

1. Last Name (as it appears on ID)	2. First Name (as it appears on ID)	3. Middle Initial
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Section B: Primary Parent/Guardian – Primary parent is listed as the caregiver on Registry card. (Photo ID required.)

4. Last Name (as it appears on ID)	5. First Name (as it appears on ID)	6. Middle Initial
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7. Mailing Address (including Apartment or Suite #)

8. City	9. State	10. Zip Code	11. Date of Birth / /	12. Telephone Number () -
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Section C: Second Parent (Photo ID required.)

13. Last Name (as it appears on ID)	14. First Name (as it appears on ID)	15. Middle Initial
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16. Mailing Address (including Apartment or Suite #)

17. City	18. State	19. Zip Code	20. Date of Birth / /	21. Telephone Number () -
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I hereby certify that the above information is correct and complete.

22. Primary Parent's Signature: 	23. Date Signed: (mm/dd/yyyy)
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The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County,
(Name of parent printed by notary) (County name)

Colorado on this _____ day of _____, 20____.
(Day) (Month)

(Notary's official signature)

(Commission expiration date)

AFFIX NOTARY SEAL

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

24. Second Parent's Signature: 	25. Date Signed: (mm/dd/yyyy)
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The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County,
(Name of parent printed by notary) (County name)

Colorado on this _____ day of _____, 20____.
(Day) (Month)

(Notary's official signature)

(Commission expiration date)

AFFIX NOTARY SEAL



Medical Marijuana Registry

Application for Registration Card for Patients Under 18

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

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	

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

Section B: Primary Parent/Guardian Information (Required) The Primary Parent/Guardian is the caregiver. The name on the form must match the legal name on caregiver's ID.				
13 Caregiver's Last Name		14. Caregiver's First Name		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)				
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 Certifications (Required) Physician name must match the name listed on the Physician Certification submitted with this application		
Physician #1	27. Physician's Last Name	28. Physician's First Name
Physician #2	28. Physician's Last Name	29. Physician's First Name

I hereby certify that the above information is correct and complete.	
30. Patient's Signature: 	31. 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
 (Name of patient printed by notary) (County name)
 on this _____ day of _____, 20____.
 (Day) (Month)

(Notary's official signature)

(Commission expiration date)

AFFIX NOTARY SEAL

STAFF ONLY

Homebound
 Yes No

Tax Exempt
 Yes No

EPU Approval
 Yes No

QA Approval
 Yes No

IU Approval/ Card Printed
 Yes No

Corrections:



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 Colorado Board of Health Rules include "**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. Contact the Registry at medical.marijuana@state.co.us or (303) 692-2184 with any questions.



Medical Marijuana Registry

Physician Certification #1 (for patients under age 18)

STAFF ONLY EPU Approval <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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. E-mail 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. <input type="checkbox"/> a. Cancer <input type="checkbox"/> b. Glaucoma <input type="checkbox"/> 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. <input type="checkbox"/> d. Cachexia <input type="checkbox"/> e. Severe nausea <input type="checkbox"/> f. Seizures <input type="checkbox"/> g. Persistent muscle spasms <input type="checkbox"/> h. Severe pain (The etiology is required by law whenever severe pain is selected.) Etiology: _____ or <input type="checkbox"/> Etiology unknown.				
23. Please indicate the number of plants and ounces of marijuana you recommend for this patient. <input type="checkbox"/> Standard Amount: 6 plants/2 ounces <input type="checkbox"/> 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 Signed: (mm/dd/yyyy)		



Medical Marijuana Registry

Physician Certification #2 (for patients under age 18)

STAFF ONLY EPU Approval <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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. E-mail 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. <input type="checkbox"/> a. Cancer <input type="checkbox"/> b. Glaucoma <input type="checkbox"/> 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. <input type="checkbox"/> d. Cachexia <input type="checkbox"/> e. Severe nausea <input type="checkbox"/> f. Seizures <input type="checkbox"/> g. Persistent muscle spasms <input type="checkbox"/> h. Severe pain (The etiology is required by law whenever severe pain is selected.) Etiology: _____ or <input type="checkbox"/> Etiology unknown.				
23. Please indicate the number of plants and ounces of marijuana you recommend for this patient. <input type="checkbox"/> Standard Amount: 6 plants/2 ounces <input type="checkbox"/> 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 Signed: (mm/dd/yyyy)		