



# Medical Marijuana Registry

## Caregiver’s Patient Limit Waiver

Patients may petition the Registry for permission to increase the number of people their caregiver can serve. The patient and caregiver must be able to clearly explain how granting an extension to the caregiver will benefit the patient’s health, safety and welfare. The caregiver must be providing services beyond growing and/or transporting medical marijuana for the patient.

### Instructions:

1. Complete this form if your caregiver is currently serving **five (5) or more** patients.
2. **Do not write-over, cross-out, or use white-out on this form, or it will be voided.** If you make a mistake on the form, please complete a new one.
3. Submit the application to the Registry within **ten (10) days** of the date of the patient’s signature.
4. If approved, the term of the waiver will be one year.
5. If the caregiver’s caseload drops to five (5) or fewer patients, the waiver is terminated.
6. After completion, the patient and caregiver must both sign and date it in front of a notary to have it notarized.
7. Include a copy of the patient’s valid photo ID and proof of residency.
8. Include a copy of the caregiver’s valid photo ID.
9. The chart below lists the documents the Registry will accept as proof of identity and residency.

PROOF OF IDENTITY AND COLORADO RESIDENCY	
<p><b>One (1) of the following</b></p> <ul style="list-style-type: none"> <li>• Colorado Driver’s License</li> <li>• Colorado ID</li> <li>• Temporary Colorado Driver’s License</li> <li>• Temporary Colorado ID</li> </ul>	<p><b>Or two (2) of the following:</b></p> <p><b>Minimum of one (1) from the group of IDs below -</b></p> <ul style="list-style-type: none"> <li>• Out of State Driver’s License</li> <li>• Out of State ID</li> <li>• Passport, Military ID (copy of front and back), Tribal ID</li> </ul> <p><b>And a minimum of one (1) from the group below -</b></p> <ul style="list-style-type: none"> <li>• Proof of Colorado Employment (paycheck stub/W-2)</li> <li>• 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.)</li> </ul>
<ol style="list-style-type: none"> <li>i. All documents must be currently valid.</li> <li>ii. Proof of residency materials must be current, within 60 days of the date the Registry receives your paperwork.</li> <li>iii. At least one (1) of these documents must show the patient’s date of birth</li> </ol>	

10. Incomplete forms will be voided and returned to you. A form is considered complete when:
  - a. The form is completed, signed and notarized.
  - b. A copy of the patient’s Colorado photo ID or non-Colorado ID and proof of residency is included.
  - c. A copy of the caregiver’s ID must be included, if the form has caregiver information.
11. Forms must be sent separately, one form per envelope.
12. Make a copy of all your paperwork. Keep the copy for your files. Submit your originals to the Registry.
13. Submit paperwork 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  
HSV-MMR  
4300 Cherry Creek Drive South  
Denver, CO 80246-1530

### Drop-Box:

Colorado Dept. of Public Health & Environment  
710 S. Ash Street, South East 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, visit our website [www.cdphe.state.co.us/hs/medicalmarijuana](http://www.cdphe.state.co.us/hs/medicalmarijuana) or call 303-692-2184.



# Medical Marijuana Registry

STAFF ONLY

Review Committee Approval  
 Yes  No

Corrections:

## Caregiver's Patient Limit Waiver

<b>Section A: Patient Information</b>					1. Social Security Number
<b>The name on the form must match the legal name on your photo ID.</b>					- -
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.

<b>Section B: Caregiver Information</b>					
<b>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.</b>					
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 ( ) -	

<b>Section C: Medical Marijuana Center Information</b>					
<b>Please provide contact information for the Medical Marijuana Center closest to the patient's residence.</b>					
22. Name of Medical Marijuana Center					
23. Mailing Address of the Medical Marijuana Center					
24. City	State CO	25. Zip Code	26. Telephone Number ( ) -		

28. How will granting this waiver benefit the patient's health, safety and welfare?

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29. What services, beyond providing medical marijuana, does the patient require for the caregiver?

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# Caregiver's Patient Limit Waiver

Patient's Name: \_\_\_\_\_ Patient's Social Security Number: \_\_\_\_\_

**STAFF ONLY**

Review Committee Approval  
 Yes  No

### 30. Patient's Signature:

Please check (✓) the box below, to consent to requested changes. By signing below, I request that the above-mentioned caregiver be granted permission to serve more than five patients. If the caregiver is granted a waiver, I request this caregiver be listed as my primary caregiver.

I hereby certify that the above information is correct and complete.	
31. Patient's Signature: 	32. 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,  
(Name of patient printed by notary) (County name)

Colorado on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(Day) (Month)

\_\_\_\_\_  
(Notary's official signature)

\_\_\_\_\_  
(Commission expiration date)

AFFIX NOTARY SEAL

Corrections:

### 33. Caregiver's Signature:

Please check (✓) the box below, to consent to the requested changes. I believe increasing the number of patients I can serve will benefit the patient's health, safety and welfare. By signing below, I consent to assuming significant responsibility for managing the patient's well-being.

I hereby certify that the above information is correct and complete.	
34. Caregiver's Signature: 	35. 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,  
(Name of caregiver printed by notary) (County name)

Colorado on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(Day) (Month)

\_\_\_\_\_  
(Notary's official signature)

\_\_\_\_\_  
(Commission expiration date)

AFFIX NOTARY SEAL