



# Medical Marijuana Registry

## Change of Homebound Status

### Instructions:

1. Complete all required sections of the form neatly and accurately.
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. After completing the form, you must sign and date it in front of a notary and have it notarized.
4. Include a copy of your valid Colorado ID. If you do not have a valid Colorado ID, you will need to submit a photo ID and proof of residency. 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>
<p>i. All documents must be currently valid when received at the Registry. Damaged, expired, or tampered IDs are not valid.</p> <p>ii. Proof of residency materials must be current, within 60 days of the date the Registry receives your paperwork.</p> <p>iii. At least one (1) of these documents must show the patient’s date of birth.</p>	

5. You may **only** change your caregiver or Medical Marijuana Center one time per month.
6. 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** an out-of-state ID and proof of Colorado residency is included.
  - c. A copy of the caregiver’s ID must be included, if the form has caregiver information.
7. Forms must be sent separately, one form per envelope.
8. Make a copy of all your paperwork. Keep the copy for your files. Submit your originals to the Registry.
9. You must submit paperwork within **ten (10) days** of the date you have it notarized.
10. 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 [www.cdphe.state.co.us/hs/medicalmarijuana](http://www.cdphe.state.co.us/hs/medicalmarijuana), call 303-692-2184 or e-mail us at [medical.marijuana@state.co.us](mailto:medical.marijuana@state.co.us).

The Medical Marijuana Registry is not affiliated with any privately operated club, organization or dispensary.



Colorado Department of Public Health and Environment

# Medical Marijuana Registry

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

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

STAFF ONLY

Homebound  
 Yes  No

EPU Approval  
 Yes  No

QA Approval Card Printed  
 Yes  No

Corrections:

## Change of Homebound Status

This form is not valid as a temporary registry card

<b>Section A: Patient Information (Required)</b> 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.

13. Please check (✓) the statement below that describes the change you are requesting.

- Change my patient status to **Homebound**.  
 Change my patient status to **Not Homebound**.

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

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

27. Patient's Signature: 	28. 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, 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



## Physician Certification Instructions

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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 sends patient verification letters monthly to physicians who have signed a Physician Certification for a patient in a specific month.
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](http://www.cdphe.state.co.us/hs/medicalmarijuana).
10. Contact the Registry at [medical.marijuana@state.co.us](mailto:medical.marijuana@state.co.us) or (303) 692-2184 with any questions.



# Medical Marijuana Registry

## 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? <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.

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 Signed: (mm/dd/yyyy)
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