Colorado Department of Public Health and Environment

Medical Marijuana Registry Application Form

(Applicant less than 18 Years of Age)

PLEASE SEE BACK OF THIS SHEET FOR INSTRUCTIONS

WHITEOUT AND CROSS-OUTS WILL VOID THIS FORM.

❑ NEW — *This is the first time I've applied in Colorado.*

❑ RENEWAL — *I have been on the Colorado Registry before.*

APPLICANT — ID Required

1. Last Name *(as it appears on your ID)*	2. First Name *(as it appears on your ID)*	3. Middle Initial

4. Mailing Address	5. City	6. Zip Code	State	7. County
			CO	

8. Social Security Number	9. Date of Birth	10. Telephone Number / 11. e-mail Address*	12. Gender
– –	/ /		M ❑ F ❑

13. Are you homebound? Yes ❑ No ❑

14. Provider of medical marijuana: Select one of the following that best describes your intended source of medical marijuana:

- ❑ Self (skip the "Provider" section below)
- ❑ Care-giver (Required: enter name and address below)
- ❑ Medical Marijuana Center (Required: enter name and address below)
- ❑ Self and Care-giver (Required: enter name and address below)
- ❑ Self and Medical Marijuana Center (Required: enter name and address below)

PROVIDER

Medical Marijuana Center

16a. Name of Medical Marijuana Center (skip this field if using a care-giver)			
16b. Mailing Address of Medical Marijuana Center	**16c.City**	**16d.State**	**16e. Zip Code**
16f. Telephone Number			

Care-Giver (ID required)

17a. Last Name of Care-Giver *(as it appears on ID)*	17b. First Name *(as it appears on ID)*	17c. Middle Initial	
17d. Mailing Address	**17e. City**	**17f. State**	**17g. Zip Code**
17h. Date of Birth / /	**17i. Telephone Number**	**17j. Alternate Number**	

PHYSICIAN

18. Last Name	19. First Name	20. Middle Initial	
21. Mailing Address	**22. City**	**23.State**	**24. Zip Code**
25. Telephone Number	**26. Fax 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.

27. Applicant's Signature: ▶	28. 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

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

Rev. July 2010

Colorado Medical Marijuana Registry Application Instructions

Instructions for applying for a Medical Marijuana Registry Identification Card
(Applicant less than 18 Years of Age)

Before sending materials, please make sure your application packet is complete. Incomplete applications will be returned to the applicant. **Whiteout and cross-outs will void this form.**

❑ **APPLICATION FOR IDENTIFICATION CARD**
- Please, legibly complete the entire application form for Applicants less than 18 Years of Age.
- Complete the Primary Caregiver Parent information form and Parental Consent form for Applicants less than 18 Years of Age.
- Complete the physician information.
- Sign and date the application and have it notarized.

❑ **PARENTAL CONSENT FORM**
- It is the responsibility of the primary caregiver parent and second parent to complete this form, sign and date the form and have it notarized.

❑ **PHYSICIAN CERTIFICATION**
- Two separate physicians must complete and sign a physician certification form for Applicants less than 18 Years of Age..
- Only an MD or DO licensed in good standing to practice medicine in the state of Colorado may sign this form.
- The Registry must receive your complete application within 60 days of the physician's signature.

❑ **A LEGIBLE PHOTO COPY OF A PHOTO ID THAT ESTABLISHES COLORADO RESIDENCY FOR THE PATIENT AND BOTH SIGNING PARENTS**
(driver's license, state ID) See below for other options. Broken or tampered ID's are not valid.

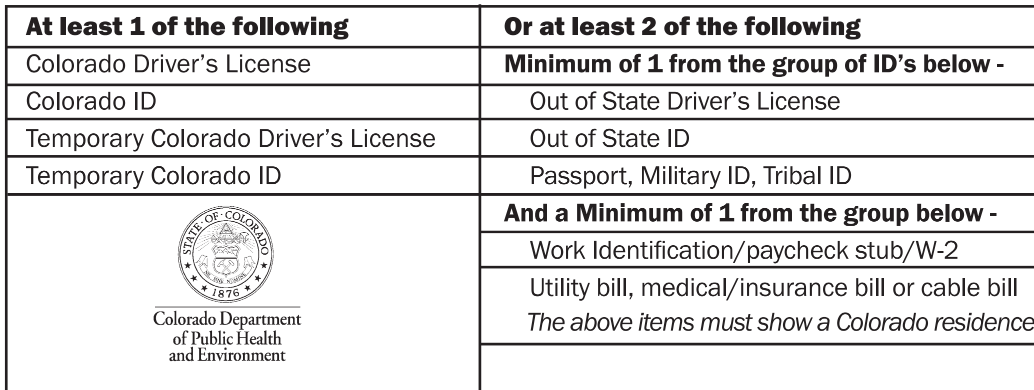
❑ **NON-REFUNDABLE $90.00 APPLICATION FEE (check or money order payable to CDPHE)**
We do not accept temporary checks and make sure form of payment is signed.

❑ **SEND ALL OF THE ITEMS ABOVE TO:**
Colorado Department of Public Health and Environment
Medical Marijuana Registry or MMR
HSVRD-MMP-A1
4300 Cherry Creek Drive South
Denver, CO 80246-1530

❑ **DROP OFF BOX:**
Colorado Department of Public Health and Environment
710 S. Ash Street, South East Entrance
Inside the first set of glass doors will be a Drop Box for MMR applications. Doors open: Monday-Friday, 7:00 a.m. to 6:00 p.m. Your application must be in a sealed envelope. You will not receive a receipt. If you wish to have a receipt, please mail in your application by certified mail.

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

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
STATE OF COLORADO 1876 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 *The above items must show a Colorado residence*

All Documents must be currently valid!
At least one of these documents must show the applicant's date of birth.

- Incomplete applications will be returned to the applicant.
- Keep copies of all the documents you submit to the Registry. For proof that your application has been submitted, you may want to send your application in by certified mail.
- The applicant will receive one card with the patient's information and primary parent caregiver information. The caregiver will not receive a card.
- Please check our web site to find the latest time estimate for processing applications.

For more information, please visit:
www.cdphe.state.co.us/hs/medicalmarijuana

WHITEOUT AND CROSS-OUTS WILL VOID THIS FORM.

Colorado Department of Public Health and Environment

Medical Marijuana Registry
(Applicant less than 18 Years of Age)

It is the responsibility of the primary caregiver parent and second parent to complete this form, sign and date the form and have it notarized.

Parental Consent Form

APPLICANT

Last Name *(as it appears on your ID)*	
First Name *(as it appears on your ID)*	Middle Initial

PRIMARY CAREGIVER PARENT

Last Name *(as it appears on your ID)*	First Name *(as it appears on your ID)*		Middle Initial
Mailing Address	City	State	Zip Code
Date of Birth / /	Telephone Number	Alternate Number	

SECOND PARENT

Last Name	First Name		Middle Initial
Mailing Address	City	State	Zip Code
Date of Birth / /	Telephone Number	Alternate Number	

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I consent to the use of medical marijuana by the minor patient named above and agree to serve as the patient's primary caregiver.

Primary Caregiver Parent Signature:	Date Signed:

The Parent'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)

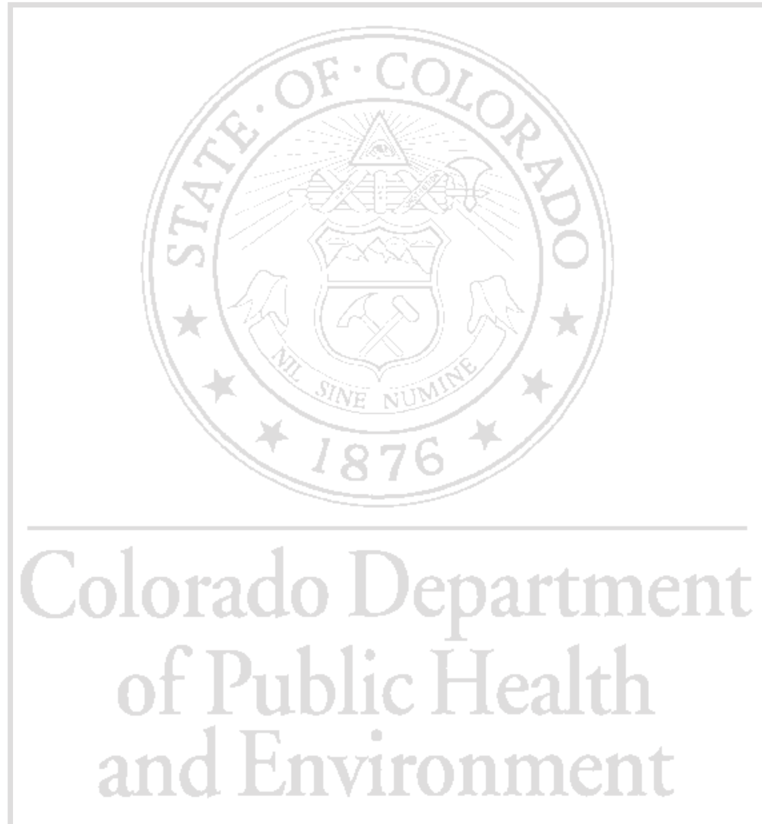
AFFIX NOTARY SEAL

Medical Marijuana Registry
(Applicant less than 18 Years of Age)

It is the responsibility of the primary caregiver parent and second parent to complete this form, sign and date the form and have it notarized.

2nd PARENT'S CONSENT

MINOR APPLICANT'S NAME: ____________________



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I consent to the use of medical marijuana by my child, the minor patient named above, and further agree to have my child's other parent act as my child's primary caregiver for purposes of the medical marijuana program.	
Second Parent Signature:	Date Signed:

The Parent'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

Medical Marijuana Registry Application Form

PHYSICIAN CERTIFICATION #1
(Applicant less than 18 Years of Age)

Instructions: Please complete all the information required on this form OR provide relevant portions of the patient's medical record that contain all the information required on this form. Sign the form, and keep a copy in the patient's medical record. The patient will submit this certification along with his or her application for a Medical Marijuana Registry identification card. This does not constitute a prescription for marijuana. **WHITEOUT AND CROSS-OUTS WILL VOID THIS FORM.** You may contact the Registry at (303) 692-2184 if you have any questions or concerns.

MINOR PATIENT INFORMATION

1. NAME (LAST, FIRST, MI):

2. DATE OF BIRTH: MM/DD/YYYY

3. DATE OF PHYSICAL EXAMINATION FOR THE PURPOSE OF MEDICAL MARIJUANA RECOMMENDATION: MM/DD/YYYY

4. HOW MANY TIMES DURING THE PREVIOUS 12 MONTHS HAVE YOU SEEN THIS PATIENT? ____________

5. ARE YOU AVAILABLE TO PROVIDE FOLLOW-UP CARE FOR THIS PATIENT? ❑ Yes ❑ No

6. RECOMMENDED DATE FOR FOLLOW-UP CARE VISIT? MM/DD/YYYY

7. IN YOUR OPINION, IS THIS PATIENT HOMEBOUND? ❑ Yes ❑ No

PHYSICIAN INFORMATION

8. NAME (LAST, FIRST, MI):

9. TELEPHONE NUMBER:

10. MAILING ADDRESS:

11. FAX NUMBER

12. CITY, STATE, AND ZIP CODE:

13. PHYSICIAN LICENSE NUMBER DR-

14. DEA NUMBER: ____________________________

Note to physician: *The Registry requires a copy of your current DEA certification to be on file with the Registry. If you have not already provided this, FAX a copy to 303-758-5182 to prevent delays in processing this application.*

PHYSICIAN'S STATEMENT

15. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic debilitating medical condition: (Check appropriate boxes.)

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

OR a chronic or debilitating disease or medical condition that produces, for this patient, 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 pain (**Required:** What is the etiology of the pain?) ____________________ ❑ Unknown

Note to physician: *The etiology is required by law whenever severe pain is selected.*

f. ❑ Severe nausea
g. ❑ Seizures (including those characteristic of epilepsy)
h. ❑ Persistent muscle spasms (including those characteristic of multiple sclerosis)

16. Comments: (if no comments, the Registry recommends crossing through this area to prevent the addition of comments after your signature)

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and tht 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, and I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

17. PHYSICIAN'S SIGNATURE:

18. DATE:

Rev. July 2010

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Colorado Department of Public Health and Environment

Medical Marijuana Registry Application Form

PHYSICIAN CERTIFICATION #2 (Applicant less than 18 Years of Age)

Instructions: Please complete all the information required on this form OR provide relevant portions of the patient's medical record that contain all the information required on this form. Sign the form, and keep a copy in the patient's medical record. The patient will submit this certification along with his or her application for a Medical Marijuana Registry identification card. This does not constitute a prescription for marijuana. **WHITEOUT AND CROSS-OUTS WILL VOID THIS FORM.** You may contact the Registry at (303) 692-2184 if you have any questions or concerns.

MINOR PATIENT INFORMATION

1. NAME (LAST, FIRST, MI):

2. DATE OF BIRTH: MM/DD/YYYY

3. DATE OF PHYSICAL EXAMINATION FOR THE PURPOSE OF MEDICAL MARIJUANA RECOMMENDATION: MM/DD/YYYY

4. HOW MANY TIMES DURING THE PREVIOUS 12 MONTHS HAVE YOU SEEN THIS PATIENT? ____________

5. ARE YOU AVAILABLE TO PROVIDE FOLLOW-UP CARE FOR THIS PATIENT? ☐ Yes ☐ No

6. RECOMMENDED DATE FOR FOLLOW-UP CARE VISIT? MM/DD/YYYY

7. IN YOUR OPINION, IS THIS PATIENT HOMEBOUND? ☐ Yes ☐ No

PHYSICIAN INFORMATION

8. NAME (LAST, FIRST, MI):

9. TELEPHONE NUMBER:

10. MAILING ADDRESS:

11. FAX NUMBER

12. CITY, STATE, AND ZIP CODE:

13. PHYSICIAN LICENSE NUMBER DR-

14. DEA NUMBER: ________________________________

Note to physician: *The Registry requires a copy of your current DEA certification to be on file with the Registry. If you have not already provided this, FAX a copy to 303-758-5182 to prevent delays in processing this application.*

PHYSICIAN'S STATEMENT

15. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic debilitating medical condition: (Check appropriate boxes.)

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

OR a chronic or debilitating disease or medical condition that produces, for this patient, 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 pain (**Required:** What is the etiology of the pain?) ______________________________ ☐ Unknown

Note to physician: *The etiology is required by law whenever severe pain is selected.*

f. ☐ Severe nausea
g. ☐ Seizures (including those characteristic of epilepsy)
h. ☐ Persistent muscle spasms (including those characteristic of multiple sclerosis)

16. Comments: (if no comments, the Registry recommends crossing through this area to prevent the addition of comments after your signature)

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and tht 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, and I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

17. PHYSICIAN'S SIGNATURE:

18. DATE:

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