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. **If you made a mistake on this form please complete a new form.** **Whiteout and cross-outs will void this form.**

1. **APPLICATION FOR IDENTIFICATION CARD**
   - Please, legibly complete the entire application form for Applicants less than 18 Years of Age.
   - Complete the Caregiver 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.
2. **PARENTAL CONSENT FORM**
   - It is the responsibility of the caregiver and second parent to complete this form, sign and date the form and have it notarized.
   - ID's and notarized consent is required from both consenting parent's/legal guardian.
3. **PLEASE INCLUDE A PHOTOCOPY OF THE PATIENT'S CERTIFIED BIRTH CERTIFICATE/CERTIFIED LEGAL GUARDIANSHIP ORDER** (This is required to prove relationship between parent(s)/legal guardian & the patient). If the second parent is living outside the state of Colorado you must prove out of state residency for that parent. If the second parent is deceased you must provide a certified copy of the parent's death certificate.
4. **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.
5. **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.
6. **NON-REFUNDABLE $90.00 APPLICATION FEE or $0 IF YOU PROVIDE PROOF OF SUPLEMENTAL SECURITY INCOME or FOOD STAMP ELIGIBILITY AS DESCRIBED BELOW**
   Check or money order payable to CDPHE. We do not accept temporary checks. Make sure the form of payment is signed. Please write the patient's name on the check. The notary cannot sign the form of payment.
   SSI: Eligibility for Supplemental Security Income is demonstrated by providing a photo copy of the patient's current "Proof of Award Letter" when the patient submits their application. The Award Letter must include: the patient's name; their benefits; effective dates; and case number. Patients may request a copy of their Award Letter at 1-800-772-1213. **Food Stamps:** Eligibility for Food Stamps is demonstrated by providing a photo copy of the patient's current "Proof of Award Letter" when the patient submits their application. The Award Letter must include: the patient's name; their benefits; effective dates; and case number. Patients may request a copy of their Award Letter from their local County Department of Human Services.
7. **1 Patient per envelope; 1 check per patient; 1 patient per certified mail receipt**
8. **SUBMIT ALL ITEMS**
   We recommend you send your paperwork by certified mail to:
   Colorado Department of Public Health and Environment
   Medical Marijuana Registry or MMR
   4300 Cherry Creek Drive South
   Denver, CO 80246-1530
9. **DROP OFF BOX:**
   Colorado Department of Public Health and Environment
   710 S. Ash Street, South East Entrance
   Inside the first set of glass doors is 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 Colorado ID Temporary Colorado Driver's License Temporary Colorado ID Colorado Department of Public Health and Environment	**Minimum of 1 from the group of ID's below -** Out of State Driver's License Out of State ID Passport, Military ID, Tribal ID **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.
- The date the patient signs and the physician signs do not have to be the same.
- Keep copies of all the documents you submit to the Registry. The law states "patients must reside in Colorado and submit the completed application form adopted by the State Health Agency." No one is permitted to submit paperwork to the Registry except the patient. 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 caregiver information, if designated.
- Please check our web site to find the latest time estimate for processing applications.
- Available Primary Care-givers: The Registry will be accepting the names of individuals who would like to be a primary care-giver and have authorized the Registry to release their contact information to patients in search of a primary care-giver. This is an optional service for those patients having difficulty finding a primary care-giver. Please check our web site for the availability of this option. Once this service is available, a Request for Primary Care-giver List form will be posted.

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

Colorado Department of Public Health and Environment

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

It is the responsibility of the Primary Parent Caregiver 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 PARENT CAREGIVER

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 *(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

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 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

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

Colorado Department of Public Health and Environment

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. **If you made a mistake on this form please complete a new form. 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. 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 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, 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:

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. **If you made a mistake on this form please complete a new form. 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. 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 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, 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:

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

If you made a mistake on this form please complete a new form. 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 **co** / 7. County
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/Parent (Required: enter name and address below) ❑ Self and Care-giver/Parent (Required: enter name and address below)	

PROVIDER

Care-Giver/Parent (ID required)

15a. Last Name *of Care-Giver/Parent* *(as it appears on ID)*	15b. First Name *(as it appears on ID)*	15c. Middle Initial
15d. Mailing Address	15e. City / 15f. State	15g. Zip Code
15h. Date of Birth / /	15i. Telephone Number	15j. Alternate Number

PHYSICIAN #1

16. Last Name	17. First Name	18. Middle Initial
19. Mailing Address	20. City / 21.State	22. Zip Code
23. Telephone Number	24. Fax Number	

PHYSICIAN #2

25. Last Name	26. First Name	27. Middle Initial
28. Mailing Address	29. City / 30.State	31. Zip Code
32. Telephone Number	33. Fax Number	

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

34. Applicant's Signature: ▶	35. 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