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

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

❑ RENEWAL
I have been on the Colorado Registry before.

APPLICANT

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

Mailing Address	City	County	State	Zip Code

Social Security Number	Date of Birth	Telephone Number	Gender
– –	/ /	Alternate Number	M ❑ F ❑

PRIMARY PARENT CAREGIVER

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

Mailing Address	City	State	Zip Code

Date of Birth	Telephone Number	Alternate Number
/ /		

PHYSICIAN

Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip Code

Telephone Number	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.

Applicant's Signature: ▶	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

Rev. August 2009

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.

❑ **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**
(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

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
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/marijuanafactsheet.html

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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 patient named above and agree to serve as the patient's primary caregiver.

Primary Caregiver Parent Signature: ▶	Date Signed:
Second Parent Signature: ▶	Date Signed:

The Parent's Signatures have 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

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 minor patient's medical record. The minor 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. You may contact the Registry at (303) 692-2184 if you have any questions or concerns.

MINOR PATIENT INFORMATION

NAME (LAST, FIRST, MI):	DATE OF BIRTH:

PHYSICIAN INFORMATION

NAME (LAST, FIRST, MI):	TELEPHONE NUMBER:
MAILING ADDRESS:	FAX NUMBER:
CITY, STATE, AND ZIP CODE:	PHYSICIAN LICENSE NUMBER DR-

PHYSICIAN'S STATEMENT

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

1. ❑ Cancer
2. ❑ Glaucoma
3. ❑ HIV or AIDS positive

OR A medical condition or treatment that produces, for this minor patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

4. ❑ Cachexia
5. ❑ Severe pain
6. ❑ Severe nausea
7. ❑ Seizures (including those characteristic of epilepsy)
8. ❑ Persistent muscle spasms (including those characteristic of multiple sclerosis)

Comments:

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 minor patient. I have assessed this patient's medical history and current medical condition, and I conclude that this minor patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

PHYSICIAN'S SIGNATURE:	DATE:

Colorado Department of Public Health and Environment

Medical Marijuana Registry

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 minor 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. You may contact the Registry at (303) 692-2184 if you have any questions or concerns.

MINOR PATIENT INFORMATION

NAME (LAST, FIRST, MI):	DATE OF BIRTH:

PHYSICIAN INFORMATION

NAME (LAST, FIRST, MI):	TELEPHONE NUMBER:
MAILING ADDRESS:	FAX NUMBER:
CITY, STATE, AND ZIP CODE:	PHYSICIAN LICENSE NUMBER DR-

PHYSICIAN'S STATEMENT

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

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OR A medical condition or treatment 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.

4. ❑ Cachexia
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7. ❑ Seizures (including those characteristic of epilepsy)
8. ❑ Persistent muscle spasms (including those characteristic of multiple sclerosis)

Comments:

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 minor patient. I have assessed this patient's medical history and current medical condition, and I conclude that this minor patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

PHYSICIAN'S SIGNATURE:	DATE: