LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Application Instructions and Checklist

(517) 284-6400

www.michigan.gov/mmp

Michigan Medical Marihuana Program
Application Form for Registry Identification Card

FOR MINOR APPLICANTS ONLY

Instructions

- Mail only **one** complete application and **all** required documentation (see below) in **one** envelope to:

Michigan Medical Marihuana Program
PO Box 30083
Lansing, MI 48909

- **Make checks or money orders payable to: State of Michigan-MMMP**
- This application is for a person who is under 18 years of age and a resident of Michigan.
- Please type or print legibly when completing the application.
- The original signed Application Form and both Physician Certification Forms must be submitted to the MMMP. Make sure to keep copies for your records.

Checklist

☐ **Minor Application Form for Registry Identification Card**
- Any use of white-out on or alterations to the Minor Application Form will result in the denial of your application.

☐ **Minor Application Fee: $85 ($60 Patient fee and $25 Caregiver fee required)**

☐ **Proof of Michigan Residency**
- Parent or legal guardian must submit copy of his or her valid Michigan driver's license, Michigan identification card, or Michigan voter registration
- Copy must be clear and legible.

☐ **Copy of proof of parentage or legal guardianship** (i.e., birth certificate or court order, etc.)

☐ **Two Physician Certification Forms**
- Two complete Physician Certification Forms must be completed and signed by two separate physicians. The physician must be a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan.
- Any use of white-out on or alterations to either Physician Certification Form will result in the denial of your application.

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(517) 284-6400

For Official Use Only MMP 3500-1 (Rev. 1/15)
□ $85 Application Fee Received

Michigan Medical Marihuana Program

Application Form for Registry Identification Card

FOR MINOR APPLICANTS ONLY

Section A: Patient Information (REQUIRED)

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4. Patient Registry ID Card Number (For Renewals Only)	5. MI Driver's License# or MI ID Card #	6. Date of Birth (MM/DD/YYYY)
P		

7a. Mailing Address	7b. Apartment/Suite/Lot #

8. City	9. State	10. Zip Code
	MI	

11. Email Address (If provided, you agree to receive email correspondence from MMMP)	12. Telephone Number

Only the parent or legal guardian listed in Section C is allowed to possess the minor applicant/patients medical marihuna plants.

Section C: Parent or Legal Guardian Information (REQUIRED)

14. Legal First Name	15. Middle Initial	16a. Legal Last Name	16b. Suffix (Jr., Sr., III, etc.)

17. Caregiver Registry Card ID Number (For Renewals Only)	18. MI Driver's License# or MI ID Card #	19. Date of Birth (MM/DD/YYYY)
C		

20a. Mailing Address	20b. Apartment/Suite/Lot #

21. City	22. State	23. Zip Code
	MI	

24. Email Address (If provided, you agree to receive email correspondence from MMMP)	25. Telephone Number

26. Other Names Used by Caregiver (Nicknames, maiden names etc. Use a separate piece of paper if you need space for additional names)

Section D: Parent/Legal Guardian Signature & Date (REQUIRED)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 et seq.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Applicant/Patient: X _____ **Date:** _____

Michigan Medical Marihuana Program

Declaration of Person Responsible for MINOR Patient

(517)284-6400 | www.michigan.gov/mmp

DECLARATION BY PARENT OR LEGAL GUARDIAN: *(REQUIRED)*

To be signed and completed by applicant/patient's Parent or Legal Guardian

This Declaration of Person Responsible must be completed and submitted with the MINOR application packet if the applicant/patient is under 18 years of age. Only the parent or legal guardian can be the primary caregiver for a minor patient. A copy of proof of parentage or legal guardianship (i.e. birth certificate or court order, etc) must be submitted with a Minor Application, failure to do so will reslt in denial of this application.

I declare each of the below statements are true and accurate:

- The applicant/patient's physicians have explained to the patient and me the potential risks and benefits of the medical use of marihuana.
- I consent to the applicant/patient's medical use of marihuana.
- I agree to serve as the applicant/patient's designated primary caregiver and agree to control the acquisition, dosage, and frequency of use of the marihuana by the applicant/patient.

Section E: Parent or Legal Guardian Declaration: (REQUIRED)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 et seq.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Parent/Legal Guardian: X _____ **Date**: _____

LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Physician Certification Form #1 for Minor Patient

(517)284-6400 | www.michigan.gov/mmp

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan

Section A: Certifying Physician Information (Required)

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4a. Full Mailing Address	4b. Apartment/Suite/Lot #

5. City	6. State	7. Zip Code	8. Telephone Number

9. Michigan Physician License Number

☐ **M.D. 4301** _____ ☐ **D.O. 5101** _____

Section B: Patient Information (Required)

10. Legal First Name	11. Middle Initial	12a. Legal Last Name	12b. Suffix (Jr., Sr., III, etc.)

13. Date of Birth

Section C: Patient's Debilitating Medical Condition(s) (Required)

This patient has been diagnosed with the following debilitating medical condition:
(A minimum of **one** box must be checked in at least **one** of the following categories.)

Category A	Category B	Category C
☐ Cancer ☐ Glaucoma ☐ HIV Positive or AIDS ☐ Hepatitis C ☐ Amyotrophic Lateral Sclerosis ☐ Crohn's Disease ☐ Agitation of Alzheimer's Disease ☐ Nail Patella	A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: ☐ Cachexia or Wasting Syndrome ☐ Severe and Chronic Pain ☐ Severe Nausea ☐ Seizures (Including but not limited to those characteristic of Epilepsy.) ☐ Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of Multiple Sclerosis.)	Check and list a condition **which has been approved** by the Medical Marihuana Review Panel: ☐ Approved medical condition: _____ _____ _____ _____

Section D: Certification, Signature and Date (Required)

By signing below, I attest that the information entered on this certification is true and accurate. I attest that I am in compliance with the Michigan Medical Marihuana Act, Administrative Rules, and all amendments. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation. Further, I attest that in my professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

Signature of Physician: X _____ **Date:** _____

LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Physician Certification Form #2 for Minor Patient

(517)284-6400 | www.michigan.gov/mmp

This certification must be completed and signed by a Medical Doctor or Doctor of Osteopathic Medicine and Surgery who is fully licensed by the State of Michigan

Section A: Certifying Physician Information (Required)

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4a. Full Mailing Address	4b. Apartment/Suite/Lot #

5. City	6. State	7. Zip Code	8. Telephone Number

9. Michigan Physician License Number

☐ **M.D. 4301** _____ ☐ **D.O. 5101** _____

Section B: Patient Information (Required)

10. Legal First Name	11. Middle Initial	12a. Legal Last Name	12b. Suffix (Jr., Sr., III, etc.)

13. Date of Birth

Section C: Patient's Debilitating Medical Condition(s) (Required)

This patient has been diagnosed with the following debilitating medical condition:
(A minimum of **one** box must be checked in at least **one** of the following categories.)

Category A	Category B	Category C
☐ Cancer ☐ Glaucoma ☐ HIV Positive or AIDS ☐ Hepatitis C ☐ Amyotrophic Lateral Sclerosis ☐ Crohn's Disease ☐ Agitation of Alzheimer's Disease ☐ Nail Patella	A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: ☐ Cachexia or Wasting Syndrome ☐ Severe and Chronic Pain ☐ Severe Nausea ☐ Seizures (Including but not limited to those characteristic of Epilepsy.) ☐ Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of Multiple Sclerosis.)	Check and list a condition **which has been approved** by the Medical Marihuana Review Panel: ☐ Approved medical condition: _____ _____ _____ _____

Section D: Certification, Signature and Date (Required)

By signing below, I attest that the information entered on this certification is true and accurate. I attest that I am in compliance with the Michigan Medical Marihuana Act, Administrative Rules, and all amendments. I attest that I have completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation. Further, I attest that in my professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

Signature of Physician: X _____ **Date:** _____

Form Reset