



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 CO	7. County
	8. Social Security Number - -		9. Date of Birth / /		10. Telephone Number	
					11. e-mail Address*	
13. Are you homebound? Yes <input type="checkbox"/> No <input type="checkbox"/>		14. Provider of medical marijuana: Select one of the following that best describes your intended source of medical marijuana:		<input type="checkbox"/> Self (skip the "Provider" section below) <input type="checkbox"/> Care-giver (Required: enter name and address below) <input type="checkbox"/> Medical Marijuana Center (Required: enter name and address below) <input type="checkbox"/> Self and Care-giver (Required: enter name and address below) <input type="checkbox"/> Self and Medical Marijuana Center (Required: enter name and address below)		
PROVIDER	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:
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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

You must complete the Registry application form and ask your physician to complete the Physician Certification form. If the applicant is a minor or you have more questions, please contact the Registry at 303.692.2184. 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.
- You may choose to designate a caregiver or a Medical Marijuana Center, although you do not have to.
- Complete the physician information.
- Sign and date in front of notary, and have notarized. The date of the patient's and the notary's signatures must be the same. The notary can not be the patient, caregiver or the physician.

PHYSICIAN CERTIFICATION

- Your physician must complete and sign the physician certification form.
- 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 CAREGIVER (if designated)

(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 the form of payment is signed. Please write the patient's name on the check. The notary cannot sign the form of payment.

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


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
 Colorado Department of Public Health and Environment	And a Minimum of 1 from the group below -
	Colo Work Identification/paycheck stub/W-2
	Utility bill, medical/insurance bill or cable bill
	<i>The above items must show a Colorado residence</i>

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

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

PAGE 1 of 2

APPLICANT	Last Name <i>(as it appears on your ID)</i>		
	First Name <i>(as it appears on your ID)</i>	Middle Initial	
PRIMARY CAREGIVER PARENT	Last Name <i>(as it appears on your ID)</i>	First Name <i>(as it appears on your ID)</i>	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)



Colorado Department of Public Health and Environment

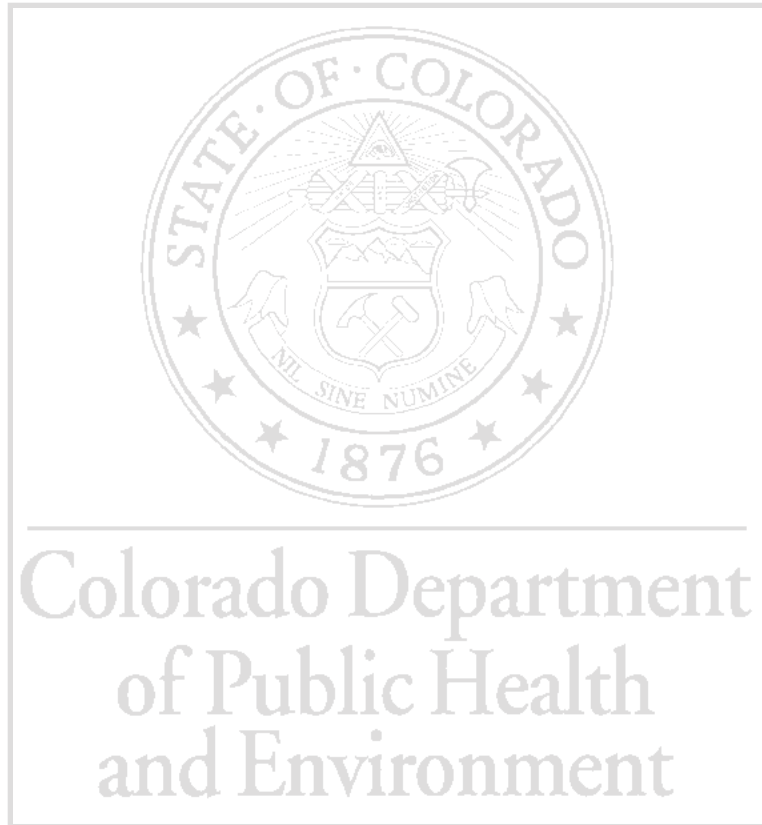
Medical Marijuana Registry (Applicant less than 18 Years of Age)

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.

2nd PARENT'S CONSENT

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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)



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. **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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. RECOMMENDED DATE FOR FOLLOW-UP CARE VISIT? MM/DD/YYYY	
7. IN YOUR OPINION, IS THIS PATIENT HOMEBOUND? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	<i>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.</i>

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. <input type="checkbox"/> Cancer	e. <input type="checkbox"/> Severe pain (Required: What is the etiology of the pain?) _____ <input type="checkbox"/> Unknown
b. <input type="checkbox"/> Glaucoma	<i>Note to physician: The etiology is required by law whenever severe pain is selected.</i>
c. <input type="checkbox"/> 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.	f. <input type="checkbox"/> Severe nausea
d. <input type="checkbox"/> Cachexia	g. <input type="checkbox"/> Seizures (including those characteristic of epilepsy)
	h. <input type="checkbox"/> 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:
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Colorado Department
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. RECOMMENDED DATE FOR FOLLOW-UP CARE VISIT? MM/DD/YYYY	
7. IN YOUR OPINION, IS THIS PATIENT HOMEBOUND? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	<i>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.</i>

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. <input type="checkbox"/> Cancer	e. <input type="checkbox"/> Severe pain (Required: What is the etiology of the pain?) _____ <input type="checkbox"/> Unknown
b. <input type="checkbox"/> Glaucoma	<i>Note to physician: The etiology is required by law whenever severe pain is selected.</i>
c. <input type="checkbox"/> 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.	f. <input type="checkbox"/> Severe nausea
d. <input type="checkbox"/> Cachexia	g. <input type="checkbox"/> Seizures (including those characteristic of epilepsy)
	h. <input type="checkbox"/> 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:
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WHITEOUT AND CROSS-OUTS WILL VOID THIS FORM.