Colorado Department of Public Health and Environment

Medical Marijuana Registry Application Form

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 ❑

CAREGIVER

❑ **None** (Skip caregiver section)	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. March 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, although you do not have to. A caregiver is defined as "a person, other than the patient and the patient's physician, who is eighteen years of age or older and has significant responsibility for managing the well-being of a patient who has a debilitating medical condition."
- Complete the physician information.
- Sign and date in front of notary, and have notarized.

❑ **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 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 caregiver information, if designated. 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

Colorado Department of Public Health and Environment

Medical Marijuana Registry

PHYSICIAN CERTIFICATION

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.

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 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 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 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.

PHYSICIAN'S SIGNATURE:	DATE: