Thank You for Choosing

MMP Certification Information Center

Let us know how you would like to be contacted for your Follow-up Visits and your Renewal Appointment.

(Email, Phone or Mail)

This information will NOT be used or given to any third party.

Name: ____

How did you hear about us? ____

Address: ____________________________

City: _______________________________

State: _______

Zip Code: ____________

E-mail: __________________________________

Phone: __________________________________

Medical Marijuana Patient Agreement

I, ______________________, the patient, agree to disclose any history of mental illness including, but not limited to depression, psychosis, suicidal thoughts/tendencies, post-traumatic stress disorder (PTSD), and substance abuse. This includes any treatment and medications prescribed. I understand that the attending physician does NOT suggest nor condone the cease of any previously prescribed medications.

Once I begin medicating with marijuana, I agree to notify my physician if I experience any of the following symptoms: depression, crying spells, loss of appetite, fatigue, mood swings, loss of interest in usual activities, withdrawal from family and friends, or changes in sleeping patterns.

There are no known interactions between marijuana and medications or other herbs. However, very few interactions between herbs and medications have been studied. I agree to disclose the use of any herbs, supplements, or other medications.

Some users develop a tolerance to marijuana, and it may require a higher dosage to achieve the same effect. I agree to notify my physician if I feel that I am developing a tolerance. Should I experience any negative side-effects in association with the use of medical marijuana, I agree to discontinue its use and report to my physician. I understand that the attending physician, staff, and representatives of MMP Certification Information Center are not providing or dispensing medical marijuana.

Release of liability

The physician, staff, and representatives are addressing specific aspects of my medical care and are in no way establishing themselves as my primary care provider. The physician is only rendering an opinion regarding the therapeutic value of medical marijuana. In no way can MMP Certification Information Center (physicians, staff, or representatives) be held liable for any harm/damage caused to myself or others in association with my use of marijuana. I also acknowledge that I have received information on the different methods of ingestion of medical marijuana. I understand that there will be some "trial and error" in developing an adequate treatment plan when using medical marijuana and agree to follow-up with the certifying physician to achieve the objectives set in my treatment period.

I certify that I have read this document and declare under penalty of perjury that the information contained herein is true, correct, and complete.

Patient: ____ Date: ____________

Physician: ______________________________________ Date: ____________

MMP Certification Information Center Downriver

18706 Eureka Road Southgate, MI 48195. 734.281.9333

MEDICAL MARIJUANA SELF-ASSESSMENT

☐ NEW ☐ RENEWAL

Patient Name	DOB	Male ☐ Female ☐
Address	City, State, ZIP	Phone

Height	Weight
Regular Physician or Clinic	
Current Medications	
Allergies to Medications	

Check all that apply

- ☐ Surgeries
- ☐ Tobacco
- ☐ Cannabis (Marijuana)
- ☐ Alcohol
- ☐ Other Illicit Drugs (please specify) ____________________

Which medical condition/symptom(s) are you here to get your license for?

- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Nausea/Vomiting
- ☐ Appetite loss/Anorexia/Cachexia
- ☐ Spinal Cord Injury
- ☐ Scoliosis
- ☐ Epilepsy/Seizures (Including, but not limited to those characteristic of Epilepsy)
- ☐ Arthritis (Muscle/Joint Pain)
- ☐ Migraine/Tension/Cluster Headaches
- ☐ Crohn's Disease/Colitis
- ☐ Discopathy (cervical disc disease)
- ☐ Depression/Anxiety/Panic Disorder
- ☐ Chronic Insomnia
- ☐ Endometriosis
- ☐ Glaucoma
- ☐ Postsurgical Pain
- ☐ Chronic Pain
- ☐ Substance Dependency (Alcohol, Opiate, etc.)
- ☐ Other______________

PLEASE SEE REVERSE SIDE →

LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

MMP 3501 A(Rev. 12/13)

Michigan Medical Marihuana Program

Application Instructions and Checklist

(517)373-0395 | www.michigan.gov/mmp

Instructions for applying to the Michigan Medical Marihuana Program

Instructions

1. 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

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

Checklist

☐ **Application Form for Registry Identification Card**

- Any use of white-out on or alterations to the Application Form will result in the denial of your application.
- **If you are acting as either the legal guardian or Medical Durable Power of Attorney (MDPOA) for the applicant,** you must submit a copy of proof of legal guardianship or MDPOA with signatory authority with the application. The MDPOA or legal guardian must also submit a copy of their valid photo ID (see copy of valid photo ID below).

☐ **Application Fee: $100**

- A patient who currently receives **full Medicaid benefits or Supplemental Security Income (SSI)** and **submits the appropriate supporting documentation** is eligible for a reduced registration fee. The reduced registration fee is $25.00. Examples of acceptable supporting documentation are available on our website at: www.michigan.gov/mmp.

☐ **Copy of Valid Photo ID** (Michigan Driver's license, Michigan ID card, or other acceptable form of ID)

- The copy of the photo ID must be clear and legible.
- If you submit a copy of a photo ID that is not a Michigan driver's license or Michigan ID card, you must also submit a copy of your Michigan voter's registration card as proof of residency.

☐ **Physician Certification Form**

- A complete Physician Certification Form 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.
- Any use of white-out on or alterations to the Physician Certification Form will result in the denial of your application.

www.michigan.gov/mmp
(517)373-0395

For Official Use Only MMP 3501 (Rev. 12/13)

Michigan Medical Marihuana Program

Application Form for Registry Identification Card

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

Section B: Person Allowed to Possess Patient's Marihuana Plants: *(REQUIRED)*

13. Plant possession: You must select one box. Failure to do so will result in the denial of your application.

SELECT ONLY ONE:
- ☐ I will possess the plants
- ☐ My caregiver will possess the plants

Section C: Caregiver Information *(If the patient is designating a caregiver)*

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 (Nick names, maiden names etc. Use a separate piece of paper if you need space for additional names)

Section D: Patient Signature & Date *(Required)*

By signing below, I attest that the information entered on this application is true and accurate. I am aware that a false or dishonest answer may be grounds for the denial or nullification of my registration and such misrepresentation is punishable by law. I attest that I have designated the person listed in Section C to serve as my caregiver (if a person is listed). I understand that I am required to know and comply with the requirements of the Michigan Medical Marihuana Act, Administrative Rules, and all amendments.

➧ **Signature of Applicant/Patient: X** ______________________ **Date:** ____________

Section E: Caregiver Attestation: *(Required if the patient is designating a caregiver)*

By signing below, I attest that the information entered on this application is true and accurate. I am aware that a false or dishonest answer may be grounds for the denial or nullification of my registration and such misrepresentation is punishable by law. I understand that I am required to know and comply with the Michigan Medical Marihuana Act, Administrative Rules, and all amendments. I authorize this agency to use the information I have provided to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial recordkeeping organization to determine if I have been convicted of any of the felony offenses that would make me ineligible to be a caregiver. I declare that I am willing and able to serve as the caregiver for the patient listed in Section A.

➧ **Signature of Caregiver: X** ______________________ **Date:** ____________