



Colorado Department
of Public Health
and Environment

Medical Marijuana Registry



CHANGE OF ADDRESS OR CARE-GIVER

INSTRUCTIONS:

When there has been a change in the name, address, or care-giver of a patient who has qualified for a registry identification card, that **patient must** notify the state health agency of any such change within **ten (10) days**. Please complete all required information in **blue ink**, sign, and date in front of notary, and have notarized. Mail this form with a legible copy of the patient's and care-giver's photo ID to:

Colorado Department of Public Health and Environment
Medical Marijuana Registry or MMR, HSVRD-MMP-A1
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530

Incomplete forms or forms without ID, will be returned to the applicant. You may contact the Registry at 303-692-2184.

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
			Alternate Number		

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."

NONE (SKIP CARE-GIVER SECTION)

CARE-GIVER	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	

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:
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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)

CHANGE OF ADDRESS OR CARE-GIVER (backside)

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 <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.