



Michigan Medical Marijuana Program
www.michigan.gov/mmp
(517)284-6400

For Official Use Only

Plant Possession Amendment

This form is for active registered **PATIENTS** who are changing their plant possession and have an **ACTIVE** Caregiver. You may also change your address at this time. If a new address is listed, we'll update your address on all active registry cards. Only one address is allowed per person in the program.

INSTRUCTIONS

1. Complete Sections A and B
2. The form must be signed and dated within six months of being received.
3. Include a copy of patient's valid Michigan driver license, personal identification card, or signed voter registration. If a patient submits a voter registration, he or she must include additional proof of identity for verification purposes (i.e., government-issued document that includes your name and date of birth).
4. Make a copy of the completed form and all required documentation for your records.
5. Do not include any other forms, fees, or documentation in the envelope.
6. Mail completed form and **all** required documentation in **one** envelope to:

Michigan Medical Marijuana Program
P.O. Box 30083
Lansing, MI 48909

Section A: Patient Information (As it appears on your current registry ID card) (REQUIRED)

Patient Registry ID Card Number (If known)	Date of Birth	Telephone Number	
Legal First Name	Middle Initial	Legal Last Name	Suffix (Jr., Sr., etc.)
Mailing Address (If your address has changed, provide your new address)		Apartment/Suite/Lot #	
City	State	Zip Code	

Section B: Plant Possession (REQUIRED)

Plant possession: You must select one box. **Select Only One:** I will possess the plants My caregiver will possess the plants

Patient Signature & Declaration (REQUIRED)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marijuana Act (Initiated Law 1 of 2008, MCL 333.26421 *et seq.*) and associated administrative rules. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution.

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