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

For Official Use Only
☐ $10 Fee Received

Remove Caregiver Form

This form is for active registered PATIENTS who are removing their current caregiver and will possess their own plants. 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. Sign and date the form.
3. Include a copy of your valid Michigan driver license, personal identification card, or signed voter registration. If you submit a voter registration, you must include additional proof of identity for verification purposes (i.e., government-issued document that includes your name and date of birth).
4. Include check or money order for $10 payable to: **State of Michigan-MMMP.**
5. Make a copy of the completed form and all required documentation for your records.
6. Do not include any other forms, fees, or documentation in the envelope.
7. Mail 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 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: Remove Current Caregiver *(REQUIRED)***

Name of Caregiver Being Removed

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 Marihuana 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:** _____