



Michigan Medical Marijuana Program  
[www.michigan.gov/mmp](http://www.michigan.gov/mmp)

(517) 284-6400

For Official Use Only

\$10 Fee Received

## Remove Patient Form

This form is for active registered CAREGIVERS who are removing one or more current PATIENT(S). 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 state-issued driver license or personal identification card.
4. Include check or money order for \$10 made payable to: **State of Michigan-MMMP** (If you are removing more than 1 patient, \$10 will cover all of the patients being removed).
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 completed form and **all** required documentation in **one** envelope to:

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

### Section A: Caregiver Information (As it appears on your current registry card) (REQUIRED)

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

### Section B: Remove Patient(s) (REQUIRED)

1. Name of patient being removed:

2. Name of patient being removed:

3. Name of patient being removed:

4. Name of patient being removed:

5. Name of patient being removed:

### Caregiver Signature and 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 Caregiver: **X**

Date: \_\_\_\_\_