

Remove Patient Form

This form is for active registered CAREGIVERS who are removing one or more current PATIENT(S).

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 Marihuana Program
P.O. Box 30083
Lansing, MI 48909

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

Caregiver 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 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 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 Caregiver: **X** _____ Date: _____