

CHANGE REQUEST FORM
Medical Marijuana Program

Instructions: Montana Medical Marijuana Registry patients must use this form to submit any changes of information to the department. **Change requests will not be accepted by the department, until the patient has been added to the registry and has received a valid Montana Medical Marijuana Card. Any change requests, concerning caregiver information, must be submitted by a valid patient and must be completed and signed by the patient and the caregiver.** If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver and the information requested on the back of this form must be completed.

- Add Caregiver
- Change Caregiver
- Name Change
- Patient's Address
- Caregiver's Address
- Other, Specify

You must have a valid medical marijuana card to submit a change request form, please enter your card number in the space provided.

Current Card Number: _____ Expiration Date: _____

QUALIFYING PATIENT INFORMANTION (REQUIRED)

NAME (LAST, FIRST, M.I.): _____ MALE _____ FEMALE _____

DATE OF BIRTH: _____ MT DRIVERS LICENSE OR STATE ID # _____ SSN _____

MAILING ADDRESS: _____ COUNTY _____ TELEPHONE NUMBER _____

CITY: _____ STATE _____ ZIP CODE _____ EMAIL ADDRESS _____
(optional)

CAREGIVER (IF APPLICABLE)

NAME (LAST, FIRST, M.I.): _____ MALE _____ FEMALE _____

DATE OF BIRTH: _____ MT DRIVERS LICENSE OR STATE ID # _____ SSN _____

MAILING ADDRESS: _____ COUNTY _____ TELEPHONE NUMBER _____

CITY: _____ STATE _____ ZIP CODE _____ EMAIL ADDRESS _____
(optional)

SIGNATURE AND DATE REQUIRED

QUALIFYING PATIENT SIGNATURE: _____ DATE: _____

"QUALIFYING PATIENT" Means a person who has been diagnosed by a physician as having a Debilitating Medical Condition.

CAREGIVER SIGNATURE: _____ DATE: _____

As the CAREGIVER for the Qualifying Patient name above, I agree to provide Medical Marijuana only to this Qualifying Patient. I have never been convicted of a felony drug offense. I understand that I am subject to a mandatory background check.

DECLARATION OF PERSON RESPONSIBLE FOR MINOR

INSTRUCTIONS: Complete all information in order to comply with the registration requirements of the Montana Medical Marijuana Act. This portion is required in addition to the patient application portion if the qualifying patient is under 18 years of age.

1. I am the __Custodial Parent or __Legal Guardian with responsibility for health care decisions for:

MINORS NAME

- 2. The applicant's attending physician has explained to the minor and me the potential risk and benefits of the medical use of marijuana.
- 3. I consent to the use of marijuana by the applicant for medical purposes.
- 4. I agree to serve as minor's designated primary caregiver; AND
- 5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the minor.

NAME (LAST, FIRST, M.I.): _____ MALE _____ FEMALE _____

DATE OF BIRTH: _____ MT DRIVERS LICENSE OR STATE ID # _____ SSN _____

MAILING ADDRESS: _____ TELEPHONE NUMBER _____

CITY: _____ STATE _____ ZIP CODE _____ EMAIL ADDRESS _____
(optional)

SIGNATURE OF CUSTODIAL PARENT OR LEGAL GUARDIAN REQUIRED: _____

MAIL APPLICATION FORM TO: DPHHS / QUALITY ASSURANCE DIVISION
LICENSURE BUREAU
PO BOX 202953
HELENA MT 59620-2953