Colorado Department of Public Health and Environment

Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
E-mail: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

MA

Medical Marijuana Registry Card Application for Patients Under 18 Years of Age

Application Instructions

Colorado Medical Marijuana Registration Cards are available **only** for Colorado residents being treated for an active, debilitating medical condition. To apply for a registration card, please complete an application packet as described below. If you make a mistake, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**

A complete application packet for patients under 18 years of age includes:

1. An Application for Registration Card completed by you, signed and notarized.
2. A Parental Consent Form completed by all parents or legal guardians living in Colorado. If a parent/legal guardian does not reside in Colorado, proof of identity and out-of-state residency must be provided.
3. Two Physician Certifications completed by two separate doctors.
4. A copy of the patient's certified birth certificate or a certified legal guardianship order.
5. A copy of the patient's valid Colorado ID.
6. A copy of both parents/guardians' valid Colorado IDs. If the Primary Parent/Caregiver does not have a Colorado ID, that parent must submit proof of identity and residency.
7. A form of payment or a Request for Fee Waiver/Tax Exempt Status form and supporting materials.

1. Application for Registration Card

a. Please complete the entire application. Write or type clearly and neatly.
b. Patient Social Security Numbers: Social security numbers are required for application submission. The Registry uses a patient's social security number as a unique number for tracking records over a period of time. Article XVIII, 14(3)(b)(II) of the Colorado Constitution states: "In order to be placed on the state's confidential registry for the medical use of marijuana, a patient must … submit the completed application form adopted by the state health agency, including the following information … (II) The name, address, date of birth, and social security number of the patient …" VISA/ITIN numbers are not accepted as a replacement for social security numbers.
c. Mark your application as 'NEW' if you have **never had a card** with the Registry. If you have ever had a card, regardless the year, mark your application as 'RENEWAL.'
d. **Ensure the mailing address is complete including apartment or lot number.** Mail returned to the Registry by the post office is retained for 90 days, then shredded.
e. You may select a Medical Marijuana Center. It is not required to have one. The Primary Parent/Guardian must be listed as the Primary Caregiver.
f. If you are under the age of 18 or homebound, you may choose both a caregiver and a Medical Marijuana Center.
g. You must sign and date this form in front of a notary. The date of your signature and the notary's signature must be the same.
h. The form cannot be notarized by the patient, the caregiver, the physician or the person who signs the payment.

2. Parental Consent Form

a. One parent or legal guardian must be listed as the "Primary Parent/Guardian." The Primary Parent/Guardian is listed on the patient's card as the Primary Caregiver. The Primary Parent/Guardian must be a Colorado resident.
b. All parents or legal guardians living in Colorado must complete the Parental Consent form.
c. All parents or legal guardians living in Colorado must sign and date this form in front of a Colorado notary. The date of parent/guardian signatures and the notary's signature must be the same.
d. The form cannot be notarized by the patient, the caregiver, the physician or the person who signs the payment.
e. Parents who do not live in Colorado must submit proof of identity and out-of-state residency.

3. Physician Certification

a. Patients under 18 years of age are required to have two Physician Certifications completed by two separate doctors.
b. The signing physician must be an MD or DO with an active Colorado medical license. Physicians with conditions or restrictions on their licenses, or out-of-state licenses, are not accepted.
c. Send in your application packet as soon as possible after the physician signs the Physician Certification. The Registry must receive your complete, correct application packet within 60 days of the physician's signature. **Application packets with Physician Certifications more than 60 days old are rejected.**
d. The Registry cannot accept paperwork on security paper that reads "VOID" when copied.

4. **Proof of Parental/Guardian Relationship**
   a. Include a copy of the patient's certified birth certificate or certified legal guardianship order. The certificate is used to prove relationship between parents(s)/legal guardians(s) and the patient.
5. **Proof of Identity and Residency**
   a. Medical Marijuana Registration cards are available only to Colorado residents. The patient and all parents living in Colorado must provide proof of identity and residency.
   b. Include a copy of the primary parent/caregiver's photo ID with the application packet.

PROOF OF IDENTITY AND COLORADO RESIDENCY		
One [1] of the following: • Colorado driver's license • Colorado photo ID • Temporary Colorado driver's license (photo not required) • Temporary Colorado ID (photo not required) **Proof of residency is not required if submitting a Colorado-issued ID.**	**OR**	**Two [2] of the following:** **Minimum of one (1) photo ID from the group below -** • Out-of-state driver's license or photo ID • U.S. passport • U.S. Military ID (copy of front and back) • Tribal ID **And a minimum of one (1) proof of residency from the group below -** • Proof of Colorado employment (paycheck stub/W-2/certified Colorado tax return) • Copy of an entire government-issued benefit letter (PERA, SSI, Disability, etc.) • Copy of a Colorado-issued certification (such as nursing, electrician, etc.) • Copy of a utility bill. All addresses on the bill must be in Colorado.

i. All documents must be currently valid when received at the Registry.
ii. Damaged, expired, or tampered IDs are not valid.
iii. The address on the photo ID **does not** have to match the mailing address on the application.
iv. All IDs must be verifiable and have specific issue and expiration dates.
v. The ID must show the patient's date of birth.
vi. Proof of residency materials must be dated within 60 days of the date the Registry receives them, unless otherwise noted.
vii. As proof of Colorado employment, the W-2 or certified Colorado tax return must be for the most recent tax year.
viii. Bills from telephone, electricity, water, trash, cable, or internet providers are considered valid and verifiable utility bills. Copies of bills must be complete, including the pay coupon. Bills must include organization name, logo and contact information.
ix. All government benefit letters must include the issuing agency's logo and contact information; the patient's name and address; and an account or case number. Examples of acceptable benefit letters include PERA, Medicaid/Medicare, Food Stamps/Food Assistance, TANF, and Social Security.
x. Certification documents must include the patient's Colorado address, be issued by a Colorado state agency and be dated within the last year.

6. **Non-refundable $35 application fee or Request for Fee Waiver:**
   The following application fee and fee waiver processes are effective for applications received January 1, 2012 or later.
   a. **To pay $35 application fee:** Make check or money order payable to CDPHE. We do not accept temporary checks. **Do not send cash.** Please write the patient's name on the payment. Make sure the form of payment is signed. The notary cannot sign the form of payment. The date of payment must be less than one (1) year old when received at the Registry. **All monies received by the Registry is nonrefundable.**
   b. **To request fee waiver:** You must submit a Fee Waiver Request (form #MMR1010) with your application packet. You may qualify for a fee waiver if your household income is at 185% of the Federal Poverty Level or less. The chart below indicates the annual household incomes, adjusted for family size, that qualify for a fee waiver.

Household incomes at 185% of 2012 Federal Poverty Guidelines*

Source: Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

# in Family	Annual Income
1	$ 20,664.50
2	$ 27,990.50
3	$ 35,316.50
4	$ 42,642.50
5	$ 49,968.50
6	$ 57,294.50
7	$ 64,620.50
8	$ 71,946.50
Each additional	$ 7,067.00

* Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)

7. **Application packets must be sent separately.** Only one application packet and check/money order per envelope. If sending by certified mail, certify each envelope separately.
8. **Please allow 4 to 6 weeks from the date the Registry receives your paperwork for application processing.** If you have not received a response within 6 weeks, please contact the Registry at 303-692-2184.

9. **Submit all items by mail or deliver to the Registry's drop-box.** The Registry does not accept forms by fax or e-mail.

Mail To:

Application Processing
Colorado Dept. of Public Health & Environment
HSV-8608
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, Southeast Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

Application Packet Checklist:

- ❑ The Application is complete and accurate.
- ❑ The Application was signed and dated by you and a Colorado notary.
- ❑ The Parental Consent form is complete, accurate and notarized.
- ❑ The dates of your signature and the notary's signature match.
- ❑ The two Physician Certifications are complete and accurate.
- ❑ The Physicians signature dates are current, within 60 days. Mail your application packet as soon as possible after your physician signs the Physician Certification.
- ❑ There are no areas on any of the forms where information has been written over, crossed out or white-out was used.
- ❑ You have included a clear, readable copy of your valid Colorado ID.
- ❑ You have included a clear, readable copy of the Primary Parent/Guardian's Colorado ID.
- ❑ If you or your Primary Parent/Guardian do not have a Colorado ID, included a copy of the out-of-state ID and proof of residency.
- ❑ If included, all copies of utility or cable bills show both the "mail to" address and the "service" address. Both addresses are in Colorado.
- ❑ You have included a copy of your certified birth certificate or certified guardianship orders.
- ❑ You have made copies of all the documents you are sending to the Registry.
- ❑ You have included a form of payment or the Request for Fee Waiver/Tax-Exempt Status form, including a certified copy of your Colorado tax return.
- ❑ Submit your application packet for yourself. Do not allow anyone else to submit the paperwork for you.
- ❑ Send your application packet by certified mail to have proof of submission. Keep the mail receipt.

Application Review Process:

1. **Initial Review:** The Registry reviews all applications against criteria described in the Application Instructions. The nonrefundable application fee, if included in the application packet, is deposited.
2. **Approved Application:** If an application packet is complete and has all supporting materials, a card is mailed to the patient.
3. **Rejected Application:** If an application packet is inaccurate or incomplete, the Registry processes the payment and keeps the submitted paperwork. A rejection letter detailing corrections needed is sent to the patient. With each rejection, patients are given 60 days to make corrections without paying additional application fees. Patients are given two (2) opportunities to submit corrections to the Registry.
4. **Approved Corrections:** When corrections are submitted to the Registry, they are reviewed for accuracy and completeness. If the application packet is complete after corrections, a card is mailed to the patient.
5. **Corrections Beyond 60-Days**: Patients who do not submit corrections within the 60-day window must submit a new application packet including a new physician certification and an additional $35 application fee.
6. **Denial:** The application is denied after the patient has submitted inaccurate or incomplete paperwork three times (the original application plus two correction attempts). The patient will have to wait six (6) months before re-applying for a Medical Marijuana Registration card, **if the application is denied**.
7. **Appeals:** If an application is denied, or the Registry suspends or revokes the patient's current registration card, a notice will be sent to the patient with details regarding the reason for denial, suspension or revocation. If the patient disagrees with a final decision from the Registry, the patient may send a letter to the Registry requesting an appeals hearing. The request for a hearing must be received by the Registry within thirty (30) calendar days from the date of the postmark on the notice.

For more information, please visit: www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.
The Registry is not affiliated with any privately operated club, organization, or dispensary.

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Parental Consent Form

STAFF ONLY

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Evaluated

Corrections:

See instructions on page 1. Photo ID required with all forms.

Section A: Patient (Photo ID and certified birth certificate -certificate of legal guardianship required.)

1. Last Name (as it appears on ID)	2. First Name (as it appears on ID)	3. Middle Initial

Section B: Primary Parent-Guardian – Primary parent is listed as the caregiver on Registry card. (Photo ID required.)

4. Last Name (as it appears on ID)	5. First Name (as it appears on ID)	6. Middle Initial

7. Mailing Address	7a. Apartment/Suite #

8. City	9. State	10. Zip Code	11. Date of Birth	12. Telephone Number

Section C: Second Parent (Photo ID required.)

13. Last Name (as it appears on ID)	14. First Name (as it appears on ID)	15. Middle Initial

16. Mailing Address	16a. Apartment/Suite #

17. City	18. State	19. Zip Code	20. Date of Birth	21. Telephone Number

I hereby certify that the above information is correct and complete.

22. Primary Parent's Signature: ▶	23. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County,
(Name of parent printed by notary) (County name)

Colorado on this _____ day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date) AFFIX NOTARY SEAL

I hereby certify that the above information is correct and complete.

24. Second Parent's Signature: ▶	25. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County,
(Name of parent printed by notary) (County name)

Colorado on this _____ day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date) AFFIX NOTARY SEAL

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MA

STAFF ONLY

_____ **Evaluated**

_____ **Data Entry 1**

_____ **Data Verified**

_____ **Finance**

_____ **Data Entry 2**

_____ **Card Printed**

Corrections:

Application for Registration Card for Patients Under 18

☐ **New:** This is the first time I have applied in Colorado. ☐ **Renewal:** I have been on the Colorado Registry before.

1. Social Security Number	**Section A: Patient Information (Required)** **The name on the form must match the legal name on your photo ID.**			
2. Last Name	3. First Name			4. Middle Initial
5a. Mailing Address		5b. Apartment/Suite #		6. City
State **CO**	7. Zip Code	8. County	9. Date of Birth	10. Telephone Number
11. E-mail Address (optional)*				12. Gender ☐ Male ☐Female

* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.

Section B: Caregiver (Required. The Primary Parent/Guardian is the caregiver)				
A copy of the caregiver's photo ID is required. The name on the form must match the legal name on the caregiver's ID. Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.				
13. Caregiver Last Name	14. Caregiver First Name			15. Middle Initial
16. Caregiver's Mailing Address				16a. Apartment/Suite #
17. City	18. State	19. Zip Code	20. Date of Birth	21. Telephone Number

Section C: Medical Marijuana Center (Optional)			
Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.			
22. Medical Marijuana Center Name			
23. Medical Marijuana Center Mailing Address			23a. Apartment/Suite #
24. City	State **CO**	25. Zip Code	26. Telephone Number
27. Fax Number	28. E-mail Address (optional)*		

I hereby certify that the above information is correct and complete.

29. Patient's Signature: ▶	30. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by

_____ in _____ County, Colorado on this
(Name of patient printed by notary) (County name)

_____day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date)

AFFIX NOTARY SEAL

Colorado Department of Public Health and Environment

Physician Certification Instructions

1. Complete the entire form, sign and date.
2. If you make a mistake on this form, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**
3. Please keep a copy of the form in the patient's medical record. To avoid fraud, the Registry verifies all physician signatures. You will receive a verification letter for patients in the months the Registry receives Physician Certifications with your signature.
4. Auto defaults:
   - If Question #7 is incomplete, the auto-default response is "no."
   - If question #21 is incomplete, the auto-default responses is "standard amount."
5. **Please do not fax or e-mail the form to the Registry.** The patient must submit the Physician Certification along with his or her complete Medical Marijuana Registry application packet.
6. This does not constitute a prescription for marijuana.
7. To sign the form, you must be an MD or DO with an active Colorado medical license. Physicians with conditions or restrictions on their licenses, or out-of-state licenses, are not accepted.
8. A copy of your current DEA certification must be on file with the Registry. If you have not already provided this, please fax a copy to 303-758-5182. If your DEA is not on file when we receive your patient's paperwork, it will be rejected.
9. **The Registry cannot accept paperwork on security paper that reads "VOID" when copied.**
10. Encourage patients to submit their application packets as soon as possible after you sign the Physician Certification. **The Registry rejects Physician Certifications that are more than 60 days old.**
11. The Registry has included in the application packet, for your review, **"Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights."** For a link to the complete Board of Health rules, please visit our website www.cdphe.state.co.us/hs/medicalmarijuana.
12. You may contact the Registry at medical.marijuana@state.co.us or (303) 692-2184, if you have any questions.

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P1

Physician Certification #1 (for patients under age 18)

STAFF ONLY

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Evaluated

Corrections:

See instructions on page 1. Photo ID required with all forms.

Patient Information

1. Last Name	2. First Name	3. Middle Initial	4. Date of Birth

5. What is the date of physical examination for the purpose of the medical marijuana recommendation? (mm/dd/yyyy)

6. Are you available to provide follow-up care for this patient? ☐Yes ☐No

7. In your opinion, is this patient homebound? ☐ Yes ☐ No

Physician Information

8. License Number DR -	9. Last Name	10. First Name	11. Middle Initial

12. Mailing Address

13. City	14. State	15. Zip Code

16. Telephone Number	17. Fax Number	18. E-mail Address (optional)

19. DEA Certification: The Registry requires a copy of your current DEA certification for their files. If you have not already provided this, **FAX a copy to 303-758-5182 to prevent delays in processing this application.**

Physician's Statement

20. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic, debilitating medical condition.

☐ a. Cancer ☐ b. Glaucoma ☐ c. HIV or AIDS positive

or The patient has a chronic or debilitating disease or medical condition that produces one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

☐ d. Cachexia ☐ e. Severe nausea ☐ f. Seizures ☐ g. Persistent muscle spasms

☐ h. Severe pain (The etiology is required by law whenever severe pain is selected.)

Etiology: _____**or** ☐ Etiology unknown.

21. Please indicate the number of plants and ounces of marijuana you recommend for this patient.

☐ Standard Amount: 6 plants/2 ounces

☐ Increased Amount: _____ plants/_____ ounces

22. Comments: (If no comments, the Registry recommends crossing through this area to prevent comments after your signature.) _____

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition. I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

23. Physician's Signature:	24. Date Signed: (mm/dd/yyyy)
▶	

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P2

Physician Certification #2 (for patients under age 18)

STAFF ONLY

_____
Evaluated

Corrections:

Patient Information

1. Last Name	2. First Name	3. Middle Initial	4. Date of Birth

5. What is the date of physical examination for the purpose of the medical marijuana recommendation? (mm/dd/yyyy)

6. Are you available to provide follow-up care for this patient? ☐Yes ☐No

7. In your opinion, is this patient homebound? ☐ Yes ☐ No

Physician Information

10. License Number DR -	11. Last Name	12. First Name	13. Middle Initial

14. Mailing Address

15. City	16. State	17. Zip Code

18. Telephone Number	19. Fax Number	20. E-mail Address (optional)

21. DEA Certification: The Registry requires a copy of your current DEA certification for their files. If you have not already provided this, **FAX a copy to 303-758-5182 to prevent delays in processing this application.**

Physician's Statement

22. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic, debilitating medical condition.

☐ a. Cancer ☐ b. Glaucoma ☐ c. HIV or AIDS positive

or The patient has a chronic or debilitating disease or medical condition that produces one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

☐ d. Cachexia ☐ e. Severe nausea ☐ f. Seizures ☐ g. Persistent muscle spasms

☐ h. Severe pain (The etiology is required by law whenever severe pain is selected.)

Etiology: _____**or** ☐ Etiology unknown.

23. Please indicate the number of plants and ounces of marijuana you recommend for this patient.

☐ Standard Amount: 6 plants/2 ounces

☐ Increased Amount: _____ plants/_____ ounces

24. Comments: (If no comments, the Registry recommends crossing through this area to prevent comments after your signature.) _____

_____

_____

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition. I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

25. Physician's Signature:	26. Date Signed: (mm/dd/yyyy)
►	