



CO L O R A D O

Medical Marijuana Registry

Department of Public Health & Environment

AP

Application for Medical Marijuana Card

Before submitting your paperwork to the Registry, make copies for your personal records. Participation in the Registry does not appear on background checks and is completely confidential.

New and Renewal Adult Applications must include:

- A complete application page
- A physician certification completed by a qualified MD or DO
- A copy of your Colorado driver's license or photo ID (or a Proof of Identity and Residency Waiver)
- A \$15 check or money order (non-refundable) made out to CDPHE (or a Fee Waiver)

For renewal applications:

Please submit renewal applications between 30 to 60 days before your card expires. Renewal applications CANNOT be used to purchase medical marijuana. You must wait until your new card arrives in the mail to purchase medical marijuana.

For applicants with legal guardians or an authorized representative:

If you are signing on behalf of the patient, you must provide a copy of your Colorado driver's license or photo ID and legal documentation granting guardianship and/or authorized representation such as a court-certified guardianship order or medical power of attorney. Medical care rights and or health care decision authority must be legally assigned in order for you to sign on behalf of the patient.

Minor applications must include:

- A complete application page
- A Parental Consent form (MC) for parents/guardians residing in Colorado
- Two (2) physician certifications completed by two (2) separate qualified MD's or DO's
- A certified copy of the minor's state-issued birth certificate (or legal guardianship order)
- A copy of both parent's/legal guardian's Colorado driver's licenses or ID's (or a Proof of Identity and Residency Waiver)
- A \$15 check or money order (non-refundable) made out to CDPHE (or a Fee Waiver form)

Proof of identity and Colorado residency requirements:

Proof of Residency Waivers are only valid for one (1) year. Upon renewing your medical marijuana card, you must provide a Colorado driver's license or photo ID.

Submit paperwork by mail or deliver to the Registry's drop-box:

Mail: Application Processing, CDPHE HSV-8630, 4300 Cherry Creek Dr S, Denver, CO 80246-1530

Deliver to drop-box: 710 S Ash St, southeast entrance, 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.

Processing time:

Please allow 3-5 weeks from the date the Registry receives your paperwork for standard processing.

Applications with Proof of Residency Waivers or caregiver requests for a caregiver who currently serves 5 or more patients may require additional time for review. If you do not receive your card or a letter from the Registry within 35 days, please contact us at 303-692-2184.



COLORADO

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Medical Marijuana Card Application

This request is for a: First time applicant Renewal applicant Minor applicant (under 18)

STAFF ONLY <hr/> Evaluated <hr/> Paid	Patient Information The mailing address listed below is for the patient and is where the card will be sent			
	1. Social Security Number		2. Date of Birth	
	3. Last Name		4. First Name	5. Middle Initial
	6a. Patient Mailing Address			6b. Apt/Ste #
	7. City		State CO	8. Zip Code
	9. County	10. Telephone	11. Email	12. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
	13. Once you receive your medical marijuana registry card, will you have a medical marijuana center grow all (or a portion of) your medical marijuana plants? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Assign a Caregiver Complete this section if you are requesting to have a cultivating or transporting caregiver			
	Adults - A Caregiver Acknowledgement form must be included with your application to assign a caregiver. Minors - A parent must be the caregiver - A Parental Consent form must be included with your application.			
	14a. Caregiver Last Name		14b. Caregiver First Name	14c. Caregiver Date of Birth
If you wish to assign a caregiver who already serves 5 or more patients, you must answer question #15. 15. What benefits do your caregiver and their products provide that improve your health and wellbeing? _____ _____ _____				
I hereby certify that I, the patient, have verified the above information to be accurate and complete and no one other than myself (or my legally authorized representative) is submitting this request on my behalf				
16a. Patient's or Authorized Representative's Signature:			16b. Signature Date	