



COLORADO

Medical Marijuana Registry

Department of Public Health & Environment



Caregiver Acknowledgment

This form must be submitted by the patient with a an Application or Change Request form and a copy of both the patient and caregiver's Colorado ID's

STAFF ONLY

Evaluated

Caregiver Information		
1. Social Security Number	2. Date of Birth	
3. First Name	4. Middle Initial	5. Last Name

Physical Address			
6. Physical Address			6a. Apt/Ste #
7. City	State CO	8. Zip Code	9. County

Mailing Address			
Is the mailing address the same as the physical address? If yes, skip to the contact information			
10. Mailing Address			10a. Apt/Ste #
11. City	State CO	12. Zip Code	13. County

Caregiver Contact Information	
14. Cell Phone\	15. Home Phone
16. Work Phone	17. Email Address

By checking this box, I authorize the Medical Marijuana Registry to contact me using the telephone number and email address I have provided above. This includes leaving messages on the contact telephone number I have provided.



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Caregiver Colorado ID or Driver's License (ID's must be Valid with the Colorado DMV)			
13. Identification Type	14. Identification Number	15a. Issue Date	15b. Expiration Date

Note: Invalid ID's and inaccurate ID information will result in your application being rejected.

Services Provided by the Caregiver			
<input type="checkbox"/> Advising	<input type="checkbox"/> Cultivating	<input type="checkbox"/> Transporting	<input type="checkbox"/> Patient/Parent/Legal Rep Registering Grow Site

14. List my contact information in the public Caregiver Directory for patients looking for medical marijuana caregiver services? Yes No

Cultivating and Transporting caregiver Information (Optional)

Note: This information will be required when the Caregiver Registry System goes live in January 2017

Cultivating Caregiver Grow Site Address where the patient's medical marijuana will be grown			
15. Address			16. Apt/Ste
17. City	State CO	18. Zip Code	19. County
20. Phone Number			

Transporting Caregiver Grow Site Address where the patient's medical marijuana will be transported from			
15. Address			16. Apt/Ste
17. City	State CO	18. Zip Code	19. County
20. Phone Number			

Signature Required

I hereby certify that I have verified the above information to be accurate and complete and no one other than myself is submitting this request on my behalf.	
16a. Caregiver's Signature:	16b. Signature Date