COLORADO
Medical Marijuana Registry
Department of Public Health & Environment

PW

Proof of Identity and Residency Waiver

This waiver must be submitted with your application and is ONLY valid for one (1) year. All renewal patients must submit a Colorado driver's license or Colorado photo ID with their application. Out of state ID's WILL NOT be accepted upon renewal.

Minor patients: Identity and residency documents must be in the primary parent's full name.

STAFF ONLY

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Evaluated

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

5a. **Submit two (2) of the following:**
Both must include your full name.

- ☐ **Out-of-state driver's license or photo ID** (must not be expired)
- ☐ **Military ID** (copies of both front and back, along with a copy of Military Orders identifying duty station, discharge or retirement letter)
- ☐ **Tribal ID** (must be issued by a federally recognized Native American Tribe)
- ☐ **U.S. Passport, Passport Card or Foreign Passport** (must include signature or both sides of card)
- ☐ **Social Security Card** (must be signed)
- ☐ **Social Services Card** (Medicaid, Medicare, mental institute card - must contain Colorado state seal)

AND

5b. **Submit two (2) of the following:**
Both must include your full name, Colorado mailing address and the issuing agency's contact information.

- ☐ **W-2** (must be for the most recent tax year)
- ☐ **Paystub** (must be issued within the last 60 days)
- ☐ **Government-issued benefit letter** (must be issued within the last calendar year)
- ☐ **Colorado voter registration** (must be issued within the last calendar year)
- ☐ **Certified Colorado state tax return** (must be a certified copy for the most recent tax year)
- ☐ **Colorado motor vehicle registration** (must not be expired)

I hereby certify that I, the patient, have verified the above information to be accurate and complete. No one other than me (or my legally authorized representative) is submitting this request on my behalf.
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.

6a. Patient's or Authorized Representative's Signature:	6b. Signature Date