COLORADO
Medical Marijuana Registry
Department of Public Health & Environment

CR

Change, Replacement or Surrender Request

In order to change, replace or surrender your medical marijuana card, complete the Patient Information section of this form and applicable the section(s).

To request a replacement card:

1. Complete section 12 of this form.
2. Include a copy of your Colorado driver's license or photo ID.

*If the print is rubbing off of your card, you must include a photo of your damaged card in order to receive a replacement.

To change your name:

1. Complete section 13 of this form.
2. Include copies of certified documentation such as a marriage certificate, divorce decree or other court documents to show your name change.
3. Include a copy of your Colorado driver's license or photo ID reflecting your new name.

To change your caregiver: (Your caregiver can only be changed once every 30 days)

To remove your caregiver

1. Complete section 13 of this form.
2. Include a copy of your Colorado driver's license or photo ID.

To add a caregiver

1. Complete section 14 of this form.
2. Include a Caregiver Acknowledgment form.
3. Include a copy of your and the caregiver's Colorado driver's licenses or photo ID's.

To change your homebound status:

1. Complete section 15 of this form.
2. Include a new Physician Certification reflecting your new homebound status.
3. Include a copy of your Colorado driver's license or photo ID.

To surrender your card:

1. Complete section 16 of this form.
2. Include a copy of your Colorado driver's license or photo ID.
3. Include your medical marijuana registry card.

For patients under the age of 18:

The primary parent/legal guardian's signature is required on all forms for patients under the age of 18 along with a copy of the primary patent's Colorado driver's license or photo ID.

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

Mail: Application Processing, CDPHE, HSV-8608, 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.

COLORADO
Medical Marijuana Registry
Department of Public Health & Environment

CR

Change, Replacement or Surrender Request

This is a request to:

☐ Receive a replacement card ☐ Change my name ☐ Change my caregiver
☐ Change my homebound status ☐ Surrender my card ☐ Change my address

STAFF ONLY

_____
Evaluated

Patient Information The mailing address listed below is for the patient and is where the card will be mailed

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

5a. Patient Mailing Address (where your card will be sent)	5b. Apt/Ste #

6. City	7. State	8. Zip Code	9. County

10. Telephone	11. Email

12. Request a Replacement Card

Card number (if known):	Date of damage/loss/theft:

My Card was: ☐ Damaged ☐ Lost ☐ Stolen ☐ Unknown

13. Change my name I have enclosed a copy of the certified, official document that proves my name change

New Name	Last Name	First Name	Middle Initial
Old Name	Last Name	First Name	Middle Initial

14. Change my Caregiver (A Caregiver Acknowledgement must be submitted with this form to add a caregiver)

This is a request to: ☐ Add a caregiver ☐ Remove my caregiver

Caregiver Last Name	Caregiver First Name	Caregiver Date of Birth

What benefits do your caregiver and their products provide that improve your health and wellbeing?

_____

_____

15. Change my Homebound Status (A new Physician Certification must be submitted with this form)

I am: ☐ Now homebound ☐ No longer homebound

16. Request to Surrender I am requesting to terminate my right to possess and use medical marijuana

Card Status: ☐ I have included my card with this form ☐ I do not have my card

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

17a. Patient's or Authorized Representative's Signature:	17b. Signature Date