CHANGE FORM

Office Use Only

Approved By:
Date of Approval:
ID #:

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

MEDICAL MARIJUANA PROGRAM - PATIENT INFORMATION CHANGE REQUEST

Instructions: Please provide your name, your date of birth and your registration number below. Check the box in the section that you would like to change and enter the new information; or indicate withdrawal from the program. Sign, date and mail the completed form to the address listed above.

Patient Name (First, M.I., Last) :	**Date of Birth:**	**Registration Number**

Provide changes to your registration information below. Check the box in the section that you wish to change.

A. PATIENT INFORMATION ☐ **Change Name or Address ($0)**

Patient Name (First, M.I., Last)	Telephone Number: ( )
Address:	Email Address:
City, State, Zip Code:	

B. PRIMARY CAREGIVER #1 ☐ **Change Name or Address ($0)** ☐ **Add New ($75 or $10)** ☐ **Drop ($0)**

Caregiver Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

C. PRIMARY CAREGIVER #2 ☐ **Change Name or Address ($0)** ☐ **Add New ($75 or $10)** ☐ **Drop ($0)**

Caregiver Name (First, M.I., Last)	Date of Birth:
Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

D. WITHDRAWAL FROM MARIJUANA PROGRAM ☐ **Withdraw from Program ($0)**

CHANGE IN DEBILITATING MEDICAL CONDITION

I no longer have the debilitating medical condition that qualified me for inclusion in the Rhode Island Medical Marijuana Program. I understand that my registration card and the registration cards of my primary caregiver(s) will become null and void as soon as the Department of Health receives this form. I agree to return my registry identification card to the Department of Health.

E. PATIENT'S ATTESTATION SIGNATURE AND DATE

I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge. I understand that if I request a duplicate card there is a ten-dollar (**$10.00**) (NON-REFUNDABLE) fee. ***I also understand that there is an application fee to add a new caregiver and that they are required to obtain a Background Check (BCI) from the Attorney General's Office and if they live out of state they need to obtain a BCI from the state in which they live as well as from Rhode Island. There is no fee to drop a current caregiver or to withdraw from the program.***

Checks or money orders must be made payable to the "General Treasurer, State of Rhode Island". If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete the form; attest to; and sign this statement. I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use this "Patient Information Change Request Form"), within ten (10) days of any changes to the information provided.

Patient's Signature:	Date of Signature:
Proxy's Signature (if applicable):	Date of Signature:

This form is to be completed by the Patient or Proxy and is for CHANGES to registration information or WITHDRAWAL only. Revised 06/23/2010 JCP