Medical Marijuana Program Change of Information Form

*This form is to be used only by **patients who are already enrolled in the Program** for one of situations listed below.*

- Patient name or address change - Must be a valid Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a Rhode Island driver's license, Rhode Island State ID, vehicle registration, voter registration, or correspondence from another State agency for benefits with a current date. ***Your name and current address must appear on the document you submit as proof of residency. If your name has changed, you must submit a legal document, such as a marriage certificate or divorce decree.***

- Withdrawal from Medical Marijuana Program - If there is a change in your debilitating medical condition or you no longer have the debilitating medical condition that qualified you for the Rhode Island Medical Marijuana Program, you can withdraw from the program. If you withdraw, your registration card and the registration cards of your primary caregiver(s) and/or authorized purchaser will become null and void as soon as the Department of Health receives this form. You must also return your registry identification card to the Department of Health.

- Authorized Purchaser name or address change - All changes of information for authorized purchasers already associated with you **must be provided by you (the patient).** If your authorized purchaser's name has changed, you must submit a legal document, such as a marriage certificate or divorce decree.

- Caregiver(s) name or address change - All changes of information for caregiver(s) already associated with you **must be provided by you (the patient)**. The caregiver must be a Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a Rhode Island driver's license, Rhode Island State ID, vehicle registration, voters registration, or correspondence from another State agency for benefits with a current date. *The caregiver's name and current address must appear on the document they submit as proof of residency. If their name has changed, they must submit a legal document, such as a marriage certificate or divorce decree.*

- Drop Caregiver or Authorized Purchaser

Pursuant to RI General Laws there is a $10 fee charged for any change(s) of information. A $10 check or money order, made payable to the General Treasurer, State of Rhode Island, should accompany this form.

Completing the Form

1. Provide your name, current Medical Marijuana Program registration number, and date of birth on the form.
2. Check the box to indicate you want to change and enter new information or you want to withdraw from the Program.
3. Sign, date, and mail this completed form to the Department of Health with a check or money for $10, payable to General Treasurer, State of Rhode Island.
4. If you are changing a Patient or Caregiver address, you must also enclose proof of residency.
5. Please keep a copy of this form. The Department of Health does not make copies of forms for the public.

Do not use this form to add new Caregiver(s) or Authorzied Purchaser.

If you want to add a new caregiver or authorized purchaser, email doh.mmp@health.ri.gov or call 401-222-3752. A form to add a caregiver or authorized purchaser will be mailed to you.

Center for Professional Licensing, Medical Marijuana Program
3 Capitol Hill, Room 105A
Providence, RI 02908-5097

Office Use Only

Approved by:
Date:
ID #:

Change of Information Form

All changes must be submitted by the patient or their proxy. This form is only for changes to registration information or withdrawal from the program.

Patient name (First, M.I., Last)

Medical Marijuana registration number

Date of birth- MM/DD/YYYY

Provide changes to your registration information below. Check the box in the section that you want to change. There is a $10 fee per form. Make check payable to: General Treasurer, State of RI.

☐ **Patient name or address changes (Proof required.)** ☐ **Withdraw from Medical Marijuana Program (No fee)**

Full name

Address

City State ZIP Code –

Phone – Email

☐ **Caregiver name or address change (Proof required.)** ☐ **Drop as Caregiver** ☐ **Drop as Patient**

Full name

Address

City State ZIP Code Date of birth – –

Phone – Email

☐ **Authorized Purchaser name or address change** ☐ **Drop as Authorized Purchaser** ☐ **Drop as Patient**

Full name

Address

City State ZIP Code Date of birth – –

Phone – Email

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 there is a **$10** non-refundable fee, **per form,** for changes.

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's Center for Professional Licensing, Medical Marijuana Program, in writing, using this *Change of Information Form*, within 10 days of any changes to the information provided.

Signature *Date*

Proxy's signature, if applicable *Date*