CHANGE FORM

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

Office Use Only

Approved By:
Date of Approval:
ID #:

MEDICAL MARIJUANA PROGRAM - PATIENT INFORMATION CHANGE REQUEST

Instructions: Please provide your name, as it appears on your registration card, 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) as it appears on your registration card:	**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 ($10.00)**

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

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

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

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

Caregiver Name (First, M.I., Last)	Date of Birth:
Mailing 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.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 08/07/2012

WE NO LONGER ACCEPT APPLICATIONS OR CHANGE FORMS IN PERSON - YOU MUST MAIL IN ALL FORMS

REGISTRATION REQUIREMENTS

Requirements for Patients

- Must be a Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a RI Driver's License, RI State ID or a copy of a lease agreement **Note: Your name must appear on the document you submit as proof of residency.**
- Complete and Sign a Patient Form
- Submit a Practitioner Form - Practitioner Form must be completed and signed by one of the following practitioner types: Physician (MD, DO) licensed to practice in RI, MA or CT, "Practitioner means a person licensed with authority to prescribe drugs pursuant to Chapter 37 of title 5 or a physician licensed with authority to prescribe drugs in Massachusetts or Connecticut.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Seventy-five dollars ($75.00) **OR** Ten dollars ($10.00) if you are a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI or SSDI. Proof must accompany the application to be eligible for the reduced fee.
- May designate up to two (2) caregivers.

Requirements for Minor Patients - (Under 18 Years of Age)

- In addition to the requirements listed above, minor patients MUST designate a custodial parent or legal guardian as one of their primary caregivers. **Additionally,** a Minor Form must be completed, signed and submitted along with the Patient Form as described above.

Requirements for Caregivers

- Caregiver information is ALWAYS provided by the Patient.
- Caregiver's MUST be twenty-one (21) years of age to apply for a caregiver registration.
- Background Check (BCI) for all caregivers. To obtain a BCI contact the Attorney General's Office at (401) 274-4400. Caregivers that live in another state must provide a BCI from the state where they live and also include one from Rhode Island. A new BCI is required **each** time a new application is submitted.
- Submit a **non-refundable** Application Fee (**Check or Money Order, Payable to RI General Treasurer**) Seventy-five dollars ($75.00) **OR** Ten dollars ($10.00) if the caregiver is a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Photocopy of Medicaid Card, Award Letter or other proof that you are a recipient of Medicaid, SSI or SSDI. Proof must accompany the application to be eligible for the reduced fee.
- Each Caregiver may be responsible for up to five (5) patients.