

**Oregon Medical Marijuana Program
CHANGE FORM**

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|--------------------------|--------------------------|
| OFFICIAL USE ONLY | |
| CHC | SSI |
| <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE TYPE OR PRINT LEGIBLY.

All areas marked **REQUIRED** must be completed. **No changes will be made** if any required section is left blank, if the full replacement card fee is not submitted, or if a required ID is not submitted.

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| A REQUIRED - PATIENT INFORMATION Check the appropriate box(es) below. | | | |
| <input type="checkbox"/> Address Change | | <input type="checkbox"/> Legal Name Change | |
| LEGAL NAME (LAST, FIRST, M.I.): | <input type="checkbox"/> Male | <input type="checkbox"/> Female | DATE OF BIRTH: |
| MAILING ADDRESS: | | | PHONE #: |
| CITY: | STATE: | ZIP CODE: | COUNTY: |
| Photo Identification: A photocopy of one of the current following ID types must be attached. Please check appropriate box: <input type="checkbox"/> OR DL / ID #: _____ <input type="checkbox"/> Other US State or Federal Issued ID #: _____ | | | |

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| B OPTIONAL - CAREGIVER INFORMATION (Not your physician) Check the appropriate box(es) below. | | | |
| <input type="checkbox"/> No Change | | <input type="checkbox"/> Change of Person (ID required) | |
| <input type="checkbox"/> Address Change | | <input type="checkbox"/> Legal Name Change | |
| LEGAL NAME (LAST, FIRST, M.I.): | <input type="checkbox"/> Male | <input type="checkbox"/> Female | DATE OF BIRTH: |
| MAILING ADDRESS: | | | PHONE #: |
| CITY: | STATE: | ZIP CODE: | COUNTY: |
| Photo Identification: A photocopy of one of the current following ID types must be attached. Please check appropriate box: <input type="checkbox"/> OR DL / ID #: _____ <input type="checkbox"/> Other US State or Federal Issued ID #: _____ | | | |

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| C REQUIRED - GROWER INFORMATION Check the appropriate box(es) below. | | | |
| <input type="checkbox"/> No Change | | <input type="checkbox"/> Change of Person (ID required) | |
| <input type="checkbox"/> Address Change | | <input type="checkbox"/> Legal Name Change | |
| LEGAL NAME (LAST, FIRST, M.I.): | <input type="checkbox"/> Male | <input type="checkbox"/> Female | DATE OF BIRTH: |
| MAILING ADDRESS: | | | PHONE #: |
| CITY: | STATE: | ZIP CODE: | COUNTY: |
| Photo Identification: A photocopy of one of the current following ID types must be attached. Please check appropriate box: <input type="checkbox"/> OR DL / ID #: _____ <input type="checkbox"/> Other US State or Federal Issued ID #: _____ | | | |

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| REQUIRED - MARIJUANA GROW SITE INFORMATION Check the appropriate box below. | | | |
| <input type="checkbox"/> No Change | | <input type="checkbox"/> Address Change | |
| PHYSICAL ADDRESS: | | | |
| CITY: | OREGON | ZIP CODE: | |
| COUNTY: | | | |

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| D REQUIRED - REPLACEMENT CARD FEE | |
| If you have a current, valid OMMP card, the replacement card fee is \$100. | |
| If your cards have not yet been issued, a grow site registration fee of \$50 is required <u>in addition to the application fee</u> if someone other than yourself is your grower. See reverse for details. | |
| Enclose your <u>check</u> or <u>money order</u> payable to "OMMP" or "OHA/State of Oregon". We do not accept debit/credit cards. | |
| <i>This form must accompany payment.</i> | |

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| E REQUIRED SIGNATURE & DATE | |
| I TESTIFY THAT THE ABOVE INFORMATION IS TRUE. | |
| APPLICANT SIGNATURE: | DATE: |



Oregon Medical Marijuana Program (OMMP)

CHANGE REQUEST FORM INSTRUCTIONS - KEEP A COPY FOR YOUR RECORDS

IF YOU DO NOT SUBMIT THE FULL REPLACEMENT CARD FEE OR IF YOUR CHANGE REQUEST FORM IS INCOMPLETE, NO CHANGES WILL BE MADE.

SECTION A – Patient Information

- The patient’s current information must be completely filled out in this section.

SECTION B – Designated Primary Caregiver

A caregiver is a person of age 18 or older who has significant responsibility for your care.

- You do not have to designate a primary caregiver unless you are under age 18.
- If you choose to list a caregiver, that person must provide a clear, legible, and valid copy of a U.S. State or Federal issued photographic identification card that includes last name, first name, and date of birth as well as his/her address and phone number.
- If you remove your caregiver, it is your responsibility to tell the caregiver that he or she is no longer protected under the Oregon Medical Marijuana Act.

SECTION C - Person Responsible for a Growsite and Marijuana Growsite Address

- All growers will be subject to a criminal history check.
- You must list the physical address in the State of Oregon where your marijuana is to be produced under Oregon Administrative Rule (OAR) 333-008-0025.
- You may list only one (1) growsite; a PO Box is not acceptable for a growsite address.
- A grower may be someone other than you or your caregiver.
- If you remove your grower, it is your responsibility to tell the grower that they are no longer protected under the Oregon Medical Marijuana Act.

SECTION D – Replacement Card Fee

- **A \$100.00 replacement card fee is only required for each form submitted changing a caregiver, grower, or growsite address after your cards have been issued.**
- **There is no fee to change a mailing address.**
- If your application for these cards was submitted with current proof of Supplemental Security Receipt, you are eligible for a reduced replacement card fee of \$20.00. Your eligibility will be confirmed.
- The change form must accompany payment. Make your check or money order payable to “OMMP” or “OHA/State of Oregon”. We do not accept credit/debit cards. Do not send cash in the mail.
- **IF YOU DO NOT SUBMIT THE FULL REPLACEMENT CARD FEE, NO CHANGES WILL BE MADE.**

SECTION E – Signature and Date

- The patient must sign and date the change form.

Mail your complete change form, required ID copies, and check or money order to:

**OMMP/OHA
PO BOX 14450
PORTLAND, OR 97293-9929**

DO NOT FAX

For More Information, Contact the OMMP at (971) 673-1234

www.healthoregon.org/mm