

**The
Oregon
Medical
Marijuana
Program**
Application Handbook

Oregon
Health
Authority

PUBLIC HEALTH
Oregon Medical Marijuana Program



PUBLIC HEALTH
Oregon Medical Marijuana Program

For more information, visit

www.healthoregon.org/ommp

or call the Oregon Medical Marijuana Program

971-673-1234

Oregon Health Authority

Oregon Medical Marijuana Program

P.O. Box 14450

Portland, OR 97293-0450

Contents

Introduction.....	1
Before applying to the OMMP.....	3
Get your physician’s recommendation	3
Make copies of your valid photo ID.....	5
Find a caregiver, if needed	6
Decide if you want to release information.....	7
Decide which way you will obtain medical marijuana.....	7
Grow your own medical marijuana.....	8
Designate someone else to grow your medical marijuana for you	8
Who is eligible to be a grower	8
How to apply.....	10
Gather these items	10
Complete the application.....	11
Pay the fee	12
Use the application checklist	16
How to make changes	18
Complete the Change Form	18
Pay the change fee.....	18
How to complete the OMMP Change Form.....	19
Refund information	20
How to renew your application	20
How to withdraw from the program	23
For more information	23

Introduction

This handbook will guide Oregon Medical Marijuana Program (OMMP) applicants to:

- Apply to become a registered cardholder.

It will also help current cardholders:

- Make registration changes;
- Renew cardholder registration;
- Withdraw from the program.

The OMMP is a state registry program within the Oregon Health Authority Public Health Division. Registration with the program allows individuals in Oregon to legally use medical marijuana with the recommendation of an attending physician for the following conditions:

- Cancer;
- Glaucoma;
- Agitation due to Alzheimer's disease;
- HIV/AIDS;
- Post-traumatic stress disorder (PTSD);
- A medical condition or treatment for a medical condition that produces one or more of the following:
 - » Cachexia (a weight-loss disease that can be caused by HIV or cancer);
 - » Severe pain;
 - » Severe nausea;
 - » Seizures, including but not limited to seizures caused by epilepsy;
 - » Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis.

New application materials



Take these steps to decide whether to apply

- Visit our website at www.healthoregon.org/ommp to:
 - Read through the “Apply for a Card” information;
 - Review the rules and statutes;
 - Review the program basic facts and frequently asked questions.
- Read through this handbook.
- Discuss the program benefits with your physician to decide if it is right for you.

If you decide to apply, send the following materials with your application. Submitting a complete application packet will help you receive your cards as quickly as possible.



Attending Physician’s Statement (APS)

APS must be received within 90 days

of the date your doctor signed the form in order for it to be valid.



Current valid U.S. state or federally issued photo ID for the patient, caregiver and grower.



\$200

Reduced fee options (if applicable)

- \$60 with proof of Oregon Food Stamps benefits (SNAP); or
- \$50 with proof of Oregon Health Plan (OHP) eligibility; or
- \$20 with proof of receipt of Supplemental Security Income (SSI) monthly benefits; or
- \$20 with proof of receipt of compensation from the United States Department of Veterans Affairs (VA) based on a finding of 100% service-connected disability or receipt of a needs-based pension from VA as described in OAR 333-008-0020.

\$50 grower site registration fee

- If a designated grower is someone other than the patient, a \$50 grower site registration fee is required in addition to the application fee.



Review the checklist on page 16 before submitting application packet.

Before applying to the OMMP

Get your physician's recommendation

Your first step in applying for an OMMP card is to receive a recommendation from an attending physician. There are two ways to do this:

A Have your physician complete the Attending Physician's Statement (APS). The attending physician must be either a doctor of medicine (MD) or a doctor of osteopathy (DO) licensed to practice in Oregon. The Oregon Medical Marijuana Act (OMMA) **does not allow** chiropractors (DC), naturopaths (ND) or nurse practitioners (NP/FNP) to sign the Attending Physician's Statement.

B You may submit medical documentation instead of an Attending Physician's Statement. A physician must complete the documentation. It must include the following:

- Your qualifying condition;
- A statement that medical marijuana may relieve the symptoms or effect of your qualifying condition; and
- The physician's signature and date.



ATTENDING PHYSICIAN'S STATEMENT
Oregon Medical Marijuana Program

Office use only: OMMP

Instructions: Please complete all sections of this form in order to comply with the registration requirements of the Oregon Medical Marijuana Act **OR** provide relevant portions of the patient's medical record containing all information required on this form. **This does not constitute a prescription for marijuana.**

If you need this document in an alternate format, please call (971) 673-1234

****This form must be received by the OMMP within 90 days of the physician's signature date.****
****You cannot renew more than three months prior to your current card expiration date.****

PLEASE TYPE OR PRINT LEGIBLY.

A PATIENT INFORMATION	
PATIENT NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE #:
CITY, STATE AND ZIP CODE:	

B PHYSICIAN INFORMATION	
PHYSICIAN NAME:	MD/DO #:
MAILING ADDRESS:	TELEPHONE #:
CITY, STATE AND ZIP CODE:	

C PHYSICIAN'S STATEMENT	
<small>Debilitating Medical Condition: Check all appropriate boxes:</small>	
<input type="checkbox"/> 1. Malignant neoplasm (Cancer)	
<input type="checkbox"/> 2. Glaucoma	
<input type="checkbox"/> 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)	
<input type="checkbox"/> 4. Agitation due to Alzheimer's Disease	
<input type="checkbox"/> 5. Post-Traumatic Stress Disorder (PTSD)	
6. A medical condition or treatment for a medical condition that produces for a specific patient one or more of the following (check all that apply):	
<input type="checkbox"/> a. Cachexia	
<input type="checkbox"/> b. Severe pain	
<input type="checkbox"/> c. Severe nausea	
<input type="checkbox"/> d. Seizures, including but not limited to seizures caused by epilepsy	
<input type="checkbox"/> e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis.	
Comments:	
<small>I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I have primary responsibility for the care and treatment of the above-named patient. The above-named patient has been diagnosed with the above debilitating medical condition(s). Marijuana used medically may mitigate the symptoms or effects of this patient's condition. This is not a prescription for the use of medical marijuana.</small>	
PHYSICIAN'S SIGNATURE:	DATE:

PATIENT MAIL ATTENDING PHYSICIAN'S STATEMENT TO:
APS 2014

OH/OMMP
PO Box 14450
Portland, OR 97293-0450

The OMMP is not directly affiliated with clinics or doctors and cannot provide physician referrals. If you need help to find a physician, you can contact a local medical marijuana advocacy group by using resources like the Internet, newspaper or a local directory.

Your attending physician will select one of the qualifying conditions listed on the APS. Please completely and legibly fill out the patient information (box A) and the physician information (box B).

OMMP must receive the Attending Physician's Statement within 90 days of the physician signing it.



Make sure boxes A and B of the Attending Physician's Statement are completely and legibly filled out.

PATIENT INFORMATION	
PATIENT NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE #:
CITY, STATE AND ZIP CODE:	

PHYSICIAN INFORMATION	
PHYSICIAN NAME:	MD/DO #:
MAILING ADDRESS:	TELEPHONE #:
CITY, STATE AND ZIP CODE:	

ATTENDING PHYSICIAN'S STATEMENT FORM

ATTENDING PHYSICIAN'S STATEMENT Oregon Medical Marijuana Program																																	
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APS 2014																																	
OHA/OMMP PO Box 14450 Portland, OR 97293-0450																																	

Make copies of your valid photo ID



Please include copies of valid U.S. state, federal or tribal issued photographic identification for the patient, grower and caregiver, as applicable. Each piece of ID must include last name, first name and date of birth. All copies of identification must include an expiration date.

Acceptable forms of state or federal-issued photographic identification are:

- Driver's license;
- State identification card;
- Passport;
- Military identification card;
- Tribal photographic identification.

Tribal photographic identification is accepted from the following nine Oregon tribes:

- Burns Paiute Tribe;
- Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians;
- Confederated Tribes of the Grand Ronde Community of Oregon;
- Confederated Tribes of Siletz Indians;
- Confederated Tribes of the Umatilla Indian Reservation;
- Confederated Tribes of Warm Springs;
- Coquille Indian Tribe;
- Cow Creek Band of Umpqua Tribe of Indians;
- Klamath Tribes.

Copies of valid identification from a non-Oregon tribe issued by a tribal government is acceptable if the identification includes full name, date of birth and a photo.

Find a caregiver, if needed

You may choose to designate a caregiver if you require assistance managing your well-being. To designate a caregiver, complete the caregiver section on your application and submit a copy of your caregiver's valid photo ID with your application.

A caregiver may be anyone over the age of 18 who can provide a valid U.S. state or federally issued photo ID. The caregiver will be able to access dispensaries on your behalf and be legally protected when transporting the patient's medical marijuana. All medical marijuana obtained by the caregiver belongs to the patient.

Please be aware that the patient, caregiver and grower may only possess a **combined total** of up to 24 ounces of usable marijuana at one time.

Caregivers for minors

If the patient is a minor, the designated caregiver must be a custodial parent or legal guardian.

The custodial parent or legal guardian must submit a **notarized Declaration of Person Responsible for a Minor to Participate in Oregon Medical Marijuana Program form**. The parent or guardian can download this form from our website or call the OMMP to have one mailed.

The Declaration of Person Responsible for a Minor to Participate in Oregon Medical Marijuana Program form must be completed annually with the patient's renewal until the patient is 18 years of age.



**Submitted annually
until 18 years of age**

Please contact the OHA/OMMP if you need this material in an alternative format.	
 DECLARATION OF PERSON RESPONSIBLE FOR A MINOR TO PARTICIPATE IN Oregon Medical Marijuana Program	
<small>MAIL COMPLETED FORM TO: OHA/OMMP, PO BOX 14450, PORTLAND, OREGON 97293-0450</small>	
<small>Instructions: Complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act. This form is required in addition to the patient application form if the patient is under 18 years of age.</small>	
DECLARATION	
I _____, do hereby declare:	
1. That I am the Custodial Parent or Legal Guardian with responsibility for health care decisions for: _____ <div style="text-align: right;"><small>Applicant's Name</small></div>	
2. The applicant's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana; 3. I consent to the use of marijuana by the applicant for medical purposes; 4. I agree to serve as the applicant's designated primary caregiver; 5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the applicant.	
SIGNATURE OF PERSON WITH PRIMARY CUSTODY:	
ADDRESS:	TELEPHONE NUMBER
CITY, STATE, AND ZIP CODE:	
Subscribed to before me on this _____ day of _____	
Notary Signature _____	
Seal/Stamp	
<small>Notary Instructions: If notary is using a raised seal, indicate in which state you are registered as a notary and the date your commission expires. Notary signature and seal must appear on this form. Do not attach a separate notary statement.</small>	
<small>OHA 8502 rev. 7/13</small>	

Decide if you want to release information

All information that a patient submits to the OMMP is confidential. The OMMP cannot release this information without the patient's prior consent.

If you would like the OMMP to discuss your registry information with someone other than yourself, you must submit a **Verbal Release of Information Request** form.

You can download the form from our website or call the OMMP to have one mailed to you.

The release is valid for one year and must be renewed annually.



Must be renewed annually

Decide which way you will obtain medical marijuana



A licensed dispensary

If you intend to obtain your medical marijuana only from a licensed dispensary, you do not need to designate a grower or a growsite on your application form.



Growing

- If you choose to grow for yourself or designate a grower, you may grow up to six mature plants and 18 seedlings or starts at your registered growsite.
- A patient and his or her grower and caregiver may possess a combined total of up to 24 ounces of usable marijuana. If you choose to designate a grower, you must list a growsite on your application. Follow these guidelines for designating a growsite:
 - » All growsites must be in Oregon.
 - » You must provide the physical address of the growsite (post office box is not acceptable).

Oregon Health Authority

Oregon Medical Marijuana Program
PO Box 14450
Portland, OR 97293-0450
(971) 673-1234 (Mon – Fri, 9:00am – 4:00pm)
www.healthoregon.org/ommp

Verbal Release of Information Request

Use this form to request that your cardholder account information may be discussed with the designee listed below over the phone. Please type or print legibly.

PATIENT Legal Name (Last, First, M.)– REQUIRED	
MAILING ADDRESS:	PHONE:

I, the above listed Patient, grant Oregon Medical Marijuana Program employees permission to discuss my account information with the following individual:

DESIGNEE Legal Name (Last, First, M.)– REQUIRED	
MAILING ADDRESS:	PHONE:

- Release of Information requests expire when the registration card expires.
- A new Release of Information must be submitted if a cardholder chooses to renew registration and would like to continue to allow the above designee access to account information.
- The Patient may revoke account access to the designee at any time through written request.
- **This form does not authorize the release of written patient records.**

PATIENT SIGNATURE & DATE – REQUIRED	
PATIENT SIGNATURE:	DATE:

Mail completed request form to:  **OHA/OMMP
PO Box 14450
Portland, OR 97293-0450**

Oregon Medical Marijuana Program • 971-673-1234 • www.healthoregon.org/ommp Rev. 10/14

Grow your own medical marijuana

Key information

- If you choose to grow your own marijuana, you must complete the grower and growsite sections on your application.
- You do not need to pay a \$50 growsite registration fee.

Designate someone else to grow your medical marijuana for you

Key information

Keep this information in mind if you choose to designate someone other than yourself to grow your medical marijuana:

- You must complete the grower and growsite sections on your application and submit a copy of your grower's valid photo ID with your application.
- There is a \$50 growsite registration fee in addition to the application fee.
- The OMMP does not keep a list of licensed growers. It is up to you to find a trustworthy grower.
- It is best to choose a grower that you know and trust. You should not sign blank OMMP forms that someone else will complete. You have the right to know who your grower is and where your medical marijuana will be grown. It may also be a good idea to have a written agreement with your grower so that each party has clear expectations.
- The patient may only reimburse the grower for the cost of supplies and utilities associated with producing it. The patient cannot reimburse for any other costs, including labor.
- All medical marijuana associated with a patient's OMMP registry card is the patient's property. This includes seedlings, mature plants and usable marijuana. The grower must return all marijuana materials whenever the patient asks for them.

Who is eligible to be a grower?

- Must be at least 18 years of age;
- Must have a valid U.S. state or federally issued photo ID;
- Must not have been convicted of any Class A or Class B felonies for manufacture or delivery of a controlled substance within the last five years;
- Must not have been convicted more than once of a Class A or Class B felony for manufacture or delivery of a controlled substance since January 01, 2006;
- Must not already be growing for four OMMP patients.



The Oregon Medical Marijuana Act does not specifically address whether or not you can be evicted for being a cardholder.

It is up to you to decide whether to tell your landlord that you are a cardholder.

If you have questions about these important issues, consult with an attorney. You may also refer to the OMMP website at www.healthoregon.org/ommp.

How to apply

Use the OMMP application checklist on page 16 in this handbook to ensure you submit all required application materials and information. This will help you receive your cards as quickly as possible.

Gather these items

- OMMP Application Form;
- Attending Physician's Statement signed by the physician within 90 days of the date OMMP receives the application;
- Copies of valid U.S. state or federally issued photo ID for the patient, as well as for the caregiver and grower if designated; and
- The appropriate fee payment.
- Note: If you are submitting an application for a minor, you will also need to submit the Declaration of Person Responsible for a Minor to Participate in Oregon Medical Marijuana Program form.



It may take up to 30 days to process the application

Application processing takes time. The OMMP staff process hundreds of applications daily in addition to answering calls. Please allow 30 days before calling to check the status of your application so we can get cards to you as quickly as possible.

Complete the application

Oregon Medical Marijuana Program
 PO Box 14450
 Portland, OR 97293-0450
 (971) 673-1234 (Mon – Fri, 9:00am - 4:00pm)
www.healthoregon.org/ommp

Office Use Only					
CHC	GR4				
FS	OHP	SSI			

APPLICATION FORM Type or print legibly. Do not alter this form or use white out.

PATIENT – REQUIRED			
LEGAL NAME (Last, First, MI):	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH:	
MAILING ADDRESS:		PHONE:	
CITY:	STATE:	ZIP:	COUNTY:
PHOTO ID # AND ISSUING AGENCY(Enclose Copy):			

CAREGIVER – OPTIONAL (Complete <i>ONLY</i> if you have a Caregiver)			
LEGAL NAME (Last, First, MI):	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH:	
MAILING ADDRESS:		PHONE:	
CITY:	STATE:	ZIP:	COUNTY:
PHOTO ID # AND ISSUING AGENCY (Enclose Copy):			

GROWER/GROWSITE – OPTIONAL (Complete <i>ONLY</i> if you have a Grower/Growsite) **CANNOT BE A DISPENSARY**			
LEGAL NAME (LAST, FIRST, MI):	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH:	
MAILING ADDRESS:		PHONE:	
CITY:	STATE:	ZIP:	COUNTY:
PHOTO ID # AND ISSUING AGENCY(Enclose Copy):			

GROWSITE ADDRESS:			
CITY:	STATE: Oregon	ZIP:	COUNTY:

FEES – REQUIRED The correct fee must be enclosed. If you are unsure please contact the OMMP.			
No GROWER/GROWSITE, OR PATIENT IS HIS/HER OWN GROWER, AND:		PATIENT IS DESIGNATING GROWER OTHER THAN HIM/HERSELF:	
Submits no reduced fee proof:	\$200.00	Submits no reduced fee proof:	\$250.00
Submits current SNAP proof:	\$60.00	Submits current SNAP proof:	\$110.00
Submits current OHP proof:	\$50.00	Submits current OHP proof:	\$100.00
Submits current SSI OR		Submits current SSI OR	
Vet 100% disability proof:	\$20.00	Vet 100% disability proof:	\$70.00

OMMP FEES ARE NON-REFUNDABLE. Enclose check or money order payable to OMMP. This form must be signed by patient. Do not staple or tape. See reverse for information on documentation required for fee types.

PATIENT SIGNATURE & DATE – REQUIRED	I TESTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.
PATIENT SIGNATURE:	DATE:

DO NOT FAX – Contact the OMMP to request this document in an alternative format.

Don't forget to sign!

Need help with your application?

Detailed instructions are included with your application, or visit our website for more information.

Need some help figuring out fees?

Reduced fee qualifications and required documentation are listed on the second page of the application.

Growsite fee. If someone other than you is growing your marijuana, a **\$50 growsite fee** is required in addition to your application fee.

Remember to include a copy of photo ID.

Copies of photo ID for patient, caregiver and grower must be included with the application.

If you or someone else will be growing your medical marijuana, the grower/growsite information **MUST BOTH** be completed. If you will **ONLY** be using dispensaries and no medical marijuana will be grown by you or for you, leave the grower/growsite sections blank.



Oregon Medical Marijuana Program
 PO Box 14450, Portland, OR 97293-0450
 Phone: (971) 673-1234, (Mon – Fri, 9:00am – 4:00pm)
www.healthoregon.org/ommp

Application Form Instructions

PATIENT INFORMATION – REQUIRED

- Patient information is required and this section must be completely filled out.
- Additional requirements must be met if the Patient is under the age of 18.

CAREGIVER INFORMATION – OPTIONAL

- If the Patient chooses to have a Caregiver, this section must be completely filled out.
- A Caregiver is not required if the Patient is 18 or older.

GROWER/GROWSITE INFORMATION – OPTIONAL

- If the Patient chooses to have a Grower/Growsite, this section must be completely filled out.
- A Dispensary may *not* be designated as either a Grower or a Growsite.
- The Authority must conduct a criminal history check on every Grower per ORS 475.304(6)(a).
- An additional fee is required if the designated Grower is not the Patient.

FEES – REQUIRED

- \$200.00** No reduced fee proof is submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.
- \$250.00** No reduced fee proof is submitted. A Grower/Growsite is listed and the Patient and Grower on the application are **different** people.
- \$60.00** Current proof of Oregon Supplemental Nutrition Assistance Program (SNAP) receipt is submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.
- \$110.00** Current proof of Oregon Supplemental Nutrition Assistance Program (SNAP) receipt is submitted. Grower/Growsite is listed and the Patient and Grower on the application are **different** people.
- \$50.00** Current proof of Oregon Health Plan receipt eligibility is submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.
- \$100.00** Current proof of Oregon Health Plan receipt eligibility is submitted. Grower/Growsite is listed and the Patient and Grower listed on the application are **different** people.
- \$20.00** Current proof of Supplemental Security Income¹ receipt eligibility is submitted. No Grower/Growsite or the Patient is his/her own Grower.
- \$70.00** Current proof of Supplemental Security Income¹ receipt eligibility is submitted. Grower/Growsite is listed and the Patient and Grower on the application are **different** people.
- \$20.00** Current proof of either service connected compensation from the VA based on a finding of 100% service connected disability OR receipt of a needs-based pension from the VA as described in OAR 333-008-0020 is submitted. Grower/Growsite is listed or the Patient is his/her own Grower.
- \$70.00** Current proof of service connected compensation from the VA based on a finding of 100% service connected disability OR receipt of a needs-based pension from the VA as described in OAR 333-008-0020 is submitted. Grower/Growsite is listed and the Patient and Grower on the application are **different** people.

¹NOTE: Social Security Disability Income (SSDI) and Social Security Retirement benefits *do not qualify*.

Patient mail complete application, Attending Physician Statement, ID copies, and check or money order to: **OHA/OMMP PO Box 14450 Portland, OR 97293-0450**

You must present your original, valid OMMP card to enter a medical marijuana dispensary. (OAR 333-008-1230, 333-008-1245) A dispensary will NOT accept a copy of your application and proof of transmission under any circumstances.

Until this application has been approved or denied by the Oregon Medical Marijuana Program, a copy of these materials (along with proof of mailing or transmission) shall have the same legal effect as a registration card. ORS 475.304(9).

The Oregon Medical Marijuana Act neither protects marijuana plants from seizure nor individuals from prosecution if the federal government chooses to take action against patients, caregivers, or growers under the federal Controlled Substances Act.

DO NOT FAX – Contact the OMMP to request this document in an alternative format.

Rev 03/2015

Pay the fee

The OMMP standard annual registration fee is \$200. There is an additional \$50 fee to register a growsite if you choose to designate a grower other than yourself.

Reduced fees

The OMMP offers several opportunities for reduced application fees. You may be eligible for one or more of them, so please review the reduced fee options and determine your eligibility before submitting your application.

If you are eligible for more than one reduced fee, only submit proof for one. We recommend you choose your lowest eligible fee. Please do not submit proof for all fees you are eligible for as it may slow down the processing of your application. **OMMP fees are non-refundable.**

SNAP

Reduced application fee: \$60

Patient is the grower or does not list a grower/growsite. Patient submits SNAP proof.

To qualify for the SNAP reduced application fee of \$60, a patient must submit one of the following:

- A photocopy of current SNAP verification;
- A photocopy of current Oregon Trail Card.

Reduced application fee and growsite registration fee: \$110

Patient is designating grower other than himself or herself. Patient submits SNAP proof.



Eligibility proof for reduced fee: SNAP



Oregon Trail card

SNAP verification examples

Oregon
John A. Eshleman, MD, Governor

Department of Human Services
Children, Adult, and Families
Self-Sufficiency Programs
1300 NW Wall Street Suite 101

DHS/Self-Sufficiency Programs
Bend Office
1300 NW Wall St Ste 101
Bend OR 97701

Verify Department Self Suff

Client Name: John Doe

Public As

TANF (Temporary Aid to Dependents)
Monthly Benefit: \$

SNAP (Supplemental Nutritional Assistance)
Monthly Benefit: \$ 497.00

Worker ID: _____ Date: _____

Signature of Employee Completing Form: _____

*Assisting People to Become An Equal Opportunity Employer

ADULT AND FAMILY SERVICES OC WCN0005R-A Notice: FSNOTES Rev 01/2008

FS SALES ADMIN
P.O. BOX 12189
SALEM, OR 97309

Program : FS
Branch : 2511
Market : OC
Case No : _____

BRANCH OFFICE
SALES ADMIN
(503) 594-5400

FS BENEFITS RE

Your food stamps for 8871 persons) and \$2,376.00. Do not give on the Internet. Change report this change by the please report when your me report other changes. no more benefits.

Oregon Administrative Rule 461-170-0102; 461-170-027

If you disagree with this you also have the right of of this form for more info

Oregon
John A. Eshleman, MD, Governor

Department of Human Services
McKenzie Center
2885 Chad Drive
Eugene, OR 97408
Phone: (541) 686-7878
Fax: (541) 686-7641
TTY: (541) 686-7528

McKenzie Center
DHS Department of Human Services

Date: JUN 06 2014

Name: John Doe

Address: 123 Main Street
Portland, OR 97202

Re: Verification of benefits received

Per your request, we are providing verification of benefits received from DHS - Self-Sufficiency Program:

TANF (Cash Assistance)
Benefit: _____

SNAP (Food Stamps)
Benefit: \$ 497.00

Medical
Benefit: _____

Employment Related Day Care
Benefit: _____

DHS Employee Name/Phone # Alice Smith 555-123-4567
Oregon Administrative Rule(s): 461-104-060

Client Signature: John Doe Date: 6/6/14

*Assisting People to Become Independent, Healthy and Safe
An Equal Opportunity Employer

OHP

Reduced application fee: \$50

Patient is the grower or not listing a grower/growsite. Patient submits OHP proof.

To qualify for the Oregon Health Plan reduced application fee of \$50, a patient must submit one of the following:

- A photocopy of current Oregon Health ID;
- A photocopy of proof of receipt of OHP benefits;
- A photocopy of current coverage letter.

Reduced application fee and growsite registration fee: \$100

Patient is designating grower other than himself or herself. Patient submits OHP proof.



Eligibility proof for reduced fee: OHP

DHS Medical Care ID

Jane Doe
Client ID #:
XX12345XX
Date card issued:
12/09/08

Oregon Health ID

OHP proof

Oregon
John A. Kitzhaber, MD, Governor

Department of Human Services
McKenzie Center
2885 Chad Drive
Eugene, OR 97408
Phone: (541) 686-7878
Fax: (541) 686-7641
TTY: (541) 686-7528

Date: AUG 16 2008

Name: John Doe

Address: 123 Main St
Portland, OR 97201

Re: Verification of benefits received

Per your request, we are providing verification of your Self Sufficiency Program:

TANF (Cash Assistance)
Benefit: _____

SNAP (Food Stamps)
Benefit: _____

Medical
Benefit: ID# XX12345

Employment Related Day Care
Benefit: _____

DHS Employee Name/Phone # Jane Doe
Oregon Administrative Rule(s): 401-10-0000

Client Signature: John Doe

*"Assisting People to Become Self-Sufficient
An Equal Opportunity for All"*

Coverage letter

Coverage Letter

The Coverage Letter is for your information only. You do not need to take it to your health care appointments. You will get a new letter when:

- ▶ You are new to the Oregon Health Plan
- ▶ You have a new CCO
- ▶ You get a new Oregon Health ID, or
- ▶ Your benefits, address or household members have changed.

0002 000000 000 000 0000 0000 0000 0000
DO NOT FORWARD - RETURN IN 2 DAYS

Branch name/Division: OHP/CAP
Worker ID/Telephone: XXXXX-555-5555

JOHN DOE
123 MAIN ST
HOMETOWN OR 97201

Keep this letter!
This letter explains your Oregon Health Plan (OHP) benefits.
This letter is just for your information. You do not need to take it to your health care appointments.
We will only send you a new letter if you have a change in your coverage, or if you request one.

Welcome to the Oregon Health Plan (OHP). This is your new coverage letter.
This letter lists coverage information for your household. This letter does not guarantee you will stay eligible for services. This letter does not override decision notices your worker sends you.
We will send you a new letter and a Medical ID card any time you request one or if any of the information in this letter or on your Medical ID card changes. To request a new letter or Medical ID, call your worker.
The enclosed yellow sheet includes a chart that describes the services covered for each benefit package and a list of helpful phone numbers.
We have listed the reason you are being sent this letter below. The date the information in this letter is effective is listed next to your name.
Reason for letter:
Managed care plan or Primary Care Manager enrollment changed for:
Doe, Timothy - 08/12/08
Names were changed for:
Doe, Jane - 08/12/08

Helpful phone numbers -
Fee-for-service (FFS) clients: call OHP Client Services - 1-800-273-0557 (TTY 711)
CCO/Plan clients: call the phone number listed on your CCO/Plan ID

Page 14

SSI

Reduced application fee: \$20

Patient is the grower or does not list a grower/growsite. Patient submits SSI proof.

To qualify for the Supplemental Security Income (SSI) reduced application fee of \$20, a patient must submit one of the following:

- A photocopy of a recent bank statement showing the SSI payment to your account;
- Receipt of SSI proof;
- SSI determination letter.

Note: Social Security Benefits (SSB) or Social Security Disability (SSD) do NOT qualify for a reduced fee.

Reduced application fee and growsite registration fee: \$70

Patient is designating grower other than himself or herself. Patient submits SSI proof.



Eligibility proof for reduced fee: SSI

Bank Of Today
221 Se Morrison ST
Portland, OR 97203

John Doe
123 Main St
Portland, OR 97202

Chequing Account

Statement Period: 2014/08/01 to 2014/08/31

Date	Description	Ref	Withdrawals	Deposits
1-Aug-2014	Previous Balance		\$0.00	\$0.00
1-Aug-2014	80114XXSUPPSEC1231736125 55588875		\$0.00	\$582.11
2-Aug-2014	Fresh Daily Supermarket	5251	\$158.24	\$0.00
15-Aug-2014	Cheque No. - 312		\$300.00	\$0.00
18-Aug-2014	Web Funds Transfer - From SAVINGS		\$0.00	\$300.00
21-Aug-2014	Fees- Monthly Checking		\$5.00	\$0.00
28-Aug-2014	Fresh Daily Supermarket	8462	\$57.33	\$0.00

Bank statement

**Social Security Administration
Supplemental Security Income**
Important Information

SOCIAL SECURITY
1538 SW YAMHILL ST
PORTLAND OR 97205
Date: April 27, 2012
Claim Number: DI

Type of Payment:
Individual-Disabled

We are writing to tell you about changes in your Supplemental Security Income (SSI) record. The rest of this letter will tell you more about this change.

About Your Request For Direct Deposit

If you have requested direct deposit of your Supplemental Security payments, your checks will be deposited directly in the bank or other institution you have selected. Even though you have direct deposit, a move or change of address still must be promptly reported to the local Social Security office, as it may affect your check.

Reporting Responsibilities

Your Supplemental Security payments may change if your situation changes. You are required to report changes that may affect your SSI no later than 10 days after the change takes place.

Call 1-800-772-1213 or contact your local Social Security office to report the following changes:

- you start or stop work, or your wages increase or decrease;
- your bank account balance goes over \$2,000.00;
- you move;
- anyone else moves into or out of your household;
- someone in your household dies;
- you marry, separate, or divorce;
- your income or resources change for you or members of your household;
- your medical condition improves;
- you leave the United States and expect to be gone for a full calendar month or for 30 consecutive days;

See Next Page

SOCIAL SECURITY ADMINISTRATION

Date: July 22, 2014
Claim Number: XXX-XX-

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, we may send them this letter.

Information About Supplemental Security Income Payments

Beginning January 2014, the current Supplemental Security Income payment is.....\$

This payment amount may change from month to month if income or living situation changes.

Supplemental Security Income Payments are paid the month they are due. For example, Supplemental Security Income Payments for March are paid in April.

IF YOU HAVE ANY QUESTIONS

We invite you to visit our web site at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any special questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 877-405-0302. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You may also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
SUITE 100
336 SW CYBER DR
BEND, OR 97702

SSI determination letter

SSI proof

VA

Reduced application fee: \$20

Patient is the grower or not listing a grower/growsite. Patient submits veterans 100% disability proof.

Reduced application fee and growsite registration fee: \$70

Patient is designating grower other than himself or herself. Patient submits veterans 100% disability proof.

To qualify for the reduced fee, submit one of the following types of proof:

- 100% VA service-connected disability;
- VA needs-based pension for non-service-connected disability.

Note: The "rate of pay" or unemployed status does not factor into whether the veteran qualifies for the reduced fee.

You can obtain a VA summary of benefits letter at www.ebenefits.va.gov or contact Veterans Affairs Benefits & Services at 1-800-827-1000.



Eligibility proof for reduced fee: VA

Non-service-connected disability



DEPARTMENT OF VETERANS AFFAIRS
Portland Regional Office
100 SW Main Street
Portland Oregon
97204

VA File Number

Represented By:
OREGON DEPARTMENT OF VETERANS AFFAIRS

Rating Decision
February 28, 2013

INTRODUCTION

The records reflect that you are a veteran of the Peacetime and Gulf War Era Navy from March 12, 1979 to March 11, 1984 and from June 28, 1991 to March 11, 1992. You filed a new claim for benefits that was received on January 13, 2012. Based on the evidence listed below, we have made the following decision(s) on your claim:

DECISION

1. Service connection for major depressive disorder is granted with an effective date of January 13, 2012.
2. Basic eligibility to Dependents' Educational Assistance is established from the date of your discharge.
3. You are considered competent.

 Department of Veterans Affairs
100 SW MAIN STREET FLOOR 2
PORTLAND OR 97204

February 26, 2014

Veteran's Name: _____

This letter is a summary of benefits you currently receive from the Department of Veterans Affairs (VA). We are providing this letter to disabled Veterans to use in applying for benefits such as housing entitlements, free or reduced state park annual membership, state or local property or vehicle tax relief, civil service preference, or any other program or entitlement that requires verification of VA service. This letter replaces VA Form 20-3455, and is considered an official record of your VA entitlement.

—America is Grateful to You for Your Service—

Our records contain the following information:

Personal Claim Information:
Your VA claim number is: _____
You are the Veteran

Military Information:
Your character(s) of discharge and service date(s) include:
Marine Corps, Honorable, 13-Jan-1969 - 12-Jan-1972
(You may have additional periods of service not listed above)

VA Benefits Information:
Service-connected disability: No
Are you receiving non-service-connected pension: **Yes**
The effective date of the last change to your current award is: 01-JAN-2014
Your current monthly award amount is: \$1,054.00

You should contact your state or local office of Veterans' Affairs for information on any tax, license, or fee-related benefits for which you may be eligible. State offices of Veterans' Affairs are available at <http://www.va.gov/statedeva.htm>.

Need Additional Information or Verification?
If you have any questions about this letter or need additional verification of VA benefits, please call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833. Send electronic inquiries through the Internet at help@iris.va.gov.

Sincerely yours,
K. L. ANDERSON
VETERANS SERVICE CENTER MANAGER

100% VA service

 Department of Veterans Affairs
100 SW MAIN STREET FLOOR 2
PORTLAND OR 97204

February 26, 2014

Veteran's Name: _____

This letter is a summary of benefits you currently receive from the Department of Veterans Affairs (VA). We are providing this letter to disabled Veterans to use in applying for benefits such as housing entitlements, free or reduced state park annual memberships, state or local property or vehicle tax relief, civil service preference, or any other program or entitlement that requires verification of VA service. This letter replaces VA Form 20-3455, and is considered an official record of your VA entitlement.

—America is Grateful to You for Your Service—

Our records contain the following information:

Personal Claim Information:
Your VA claim number is: _____
You are the Veteran

Military Information:
Your character(s) of discharge and service date(s) include:
Army, Honorable, 02-May-1990 - 06-Jan-1992
(You may have additional periods of service not listed above)

VA Benefits Information:
Service-connected disability: Yes
Your combined service-connected evaluation is: **100%**
The effective date of the last change to your current award is: 01-JAN-2014
Your current monthly award amount is: \$1,212.40

You should contact your state or local office of Veterans' Affairs for information on any tax, license, or fee-related benefits for which you may be eligible. State offices of Veterans' Affairs are available at <http://www.va.gov/statedeva.htm>.

Need Additional Information or Verification?
If you have any questions about this letter or need additional verification of VA benefits, please call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833. Send electronic inquiries through the Internet at help@iris.va.gov.

Sincerely yours,
K. KALAMA
VETERANS SERVICE CENTER MANAGER

Use the application checklist

Patients who submit their application with all the correct documentation generally receive their cards faster than those who submit incomplete applications. The following checklist will help you submit a complete application.

Note: A copy of your submitted written application along with proof of the date of mailing or transmission gives you the same legal protection as a registry identification card. This will apply until you receive your card or a notice that the OMMP has approved, denied or rejected your application. Written documentation of your application does not allow you access to dispensaries.



Checklist:

Is your Attending Physician's Statement (APS) complete and signed by a medical doctor (MD) or doctor of osteopathy (DO) licensed in Oregon?



We must receive the APS within 90 days of the date your doctor signed the form in order for it to be valid.

Is your application form complete and did you sign it?

Have you included valid photographic ID for everyone listed on the application form?

Have you included the appropriate fee?

***** Keep a copy of all application materials for your records *****

The application fee is \$200 unless you qualify for one of the reduced fees. See pages 12–15 for reduced fees information.

After you have double-checked your paperwork, send or deliver your completed application materials as follows:



Send completed application materials by certified mail to:

**OHA/OMMP
P.O. Box 14450
Portland, OR 97293-0450**



You can also deliver them to our secure drop box located on the first floor of the Portland State Office Building.

**800 N.E. Oregon Street, First Floor
Portland, Oregon 97232-2162**

How to make changes

Once you are a cardholder, you must notify OMMP in writing within 30 days of any changes to:

- Your mailing address;
- The growsite address;
- Your designation of a caregiver or grower.

Complete the Change Form

In order to make a change to your current registration, you need to submit a complete Change Form. You can download the form from our website or call the OMMP to have one mailed to you.

When filling out the Change Form remember to:

- Sign and date the form;
- Submit copies of valid photo ID for any new caregiver and/or grower added to the registry;
- Make copies of all submitted documents for your records.

Pay the change fee

A \$100 replacement card fee is required to add a caregiver or grower or to update the growsite address after the OMMP has issued your cards.

The replacement card fee is reduced to \$20 if the patient submits proof of Supplemental Security Income (SSI) or proof of compensation from the United States Department of Veterans Affairs (VA) based on a finding of 100% service-connected disability or receipt of a needs-based pension from the VA as described in OAR 333-008-0020.

No fee payment is required to:

- Change mailing addresses;
- Remove a caregiver;
- Remove a grower/growsite.

How to complete the OMMP Change Form



Changes must be reported to the OMMP within 30 days

The patient information section must be completely filled out for **ALL** changes.

Removing a caregiver and/or grower:
Remove your caregiver or grower by checking the "Remove Caregiver" or "Remove Grower/Growsite" box.

Make sure to enclose the correct replacement card fee if you are changing caregiver, grower and/or growsite.

Oregon Medical Marijuana Program
 PO Box 14450
 Portland, OR 97293-0450
 (971) 673-1234 (Mon – Fri, 9:00am - 4:00 pm)
 www.healthoregon.org/ommp

Office Use Only
 CHC GR4 SSI

CHANGE FORM Type or print legibly. All areas marked **REQUIRED** must be completed.

PATIENT: REQUIRED
 LEGAL NAME (Last, First, MI): Male Female DATE OF BIRTH:
 MAILING ADDRESS: PHONE:
 CITY: STATE: ZIP: COUNTY:

CAREGIVER: OPTIONAL (Complete **ONLY** if you want to change your current Caregiver information)
CHECK Change Request Type: Remove Caregiver Update Current Caregiver information Add new Caregiver*
 LEGAL NAME (Last, First, MI): Male Female DATE OF BIRTH:
 MAILING ADDRESS: PHONE:
 CITY: STATE: ZIP: COUNTY:
 PHOTO ID# AND ISSUING AGENCY (Enclose Copy):

GROWER/GROWSITE: OPTIONAL (Complete **ONLY** if you want to change your current Grower/Growsite)
****CANNOT BE A DISPENSARY****
CHECK Change Request Type: Remove Grower/Growsite Update Current Grower/Growsite information Add new Grower/Growsite*
 LEGAL NAME (LAST, FIRST, MI): Male Female DATE OF BIRTH:
 MAILING ADDRESS: PHONE:
 CITY: STATE: ZIP: COUNTY:
 PHOTO ID # AND ISSUING AGENCY (Enclose Copy):

GROWSITE ADDRESS:
 CITY: STATE: Oregon ZIP: COUNTY:

*If you have a new Caregiver or Grower, you must enclose a copy of the new Caregiver or Grower's state or federal issued photo ID.

REPLACEMENT CARD FEES- REQUIRED
 The correct fee must be enclosed in order for your change request to be completed.
 If you have a current OMMP card: \$100
 If you have a current OMMP card **and** have submitted current SSJ or Vet 100% Disability proof (see reverse for more information on what proof is needed): \$20.
 OMMP fees are non-refundable. Enclose a check or money order payable to "OMMP". This form must be sent with the payment. Do not staple or tape. See reverse for additional information.

PATIENT SIGNATURE & DATE – REQUIRED | I TESTIFY THAT THE ABOVE INFORMATION IS TRUE:
 PATIENT SIGNATURE: DATE:

DO NOT FAX – Contact the OMMP to request this document in an alternative format. Rev 03/2015

Replacing a caregiver and/or grower:
If you would like to replace your current caregiver and/or grower/growsite, check the "Update Current Caregiver" and/or "Update Current Grower/Growsite" box.

Adding new caregiver and/or grower:
If you are currently without a caregiver and/or grower/growsite and need to add a new one, check the "Add new Caregiver" and/or "Add new Grower/Growsite" box.

Don't forget to sign!

Don't forget! You must attach a copy of valid photo ID for a new caregiver and/or grower.

Refund information

OMMP fees are non-refundable. However, an applicant may be refunded for overpayments under certain circumstances.

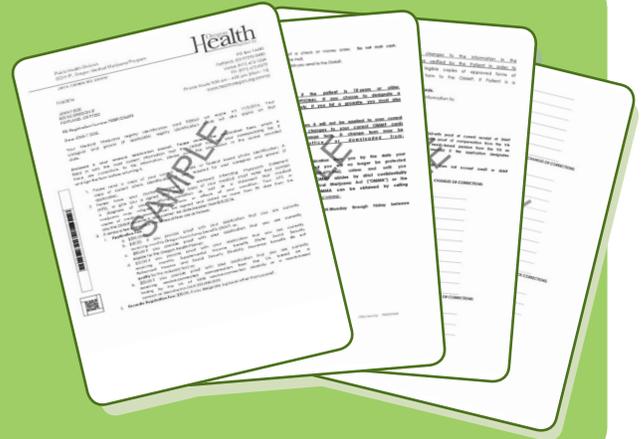
How to renew your application

Cardholders must renew their registration every year. When it is time to renew, you will receive a renewal packet in the mail.



Renewal packet will include:

- Renewal instructions;
- An application form including current registration information;
- An Attending Physician's Statement form; and
- Your current card expiration date.



Submit the following to renew your registration:

- Complete application form (make sure all information is up to date, including caregiver and grower/growsite information);
- Copies of valid U.S. state or federally issued photo IDs for everyone listed on the application;
- Complete Attending Physician's Statement form.
- Fee payment (see pages 12–15 for fee schedule);
- Declaration of Person Responsible for a Minor to Participate in Oregon Medical Marijuana Program form (if you are registering a minor).



If the OMMP does not receive your complete renewal application by the current registration card expiration date, your registration card will no longer be valid, and you will no longer be protected from civil and criminal penalties.

Changes made to your renewal application are **NOT applied to your current registration**. If you need to make a change to your current registration, fill out the Change Form.

Renewal registration materials



OMMP renewal packet

Review renewal packet information and make sure all is up-to-date, including caregiver and grower/growsite information.

Include the following materials with your renewal application. Submitting a complete application packet will help you receive your cards as quickly as possible.



Attending Physician's Statement (APS)

APS must be received within 90 days of your current registration expiration date.



If you send your renewal application more than 90 days before your current card expires, your Attending Physician's Statement will not be valid.



Current valid U.S. state or federally issued photo ID for the patient, caregiver and grower



Appropriate fee payment

\$200 application fee

Reduced fee options (if applicable)

- \$60 with proof of Oregon Food Stamps benefits (SNAP); or
- \$50 with proof of Oregon Health Plan (OHP) eligibility; or
- \$20 with proof of receipt of Supplemental Security Income (SSI) monthly benefits; or
- \$20 with proof of receipt of compensation from the United States Department of Veterans Affairs (VA) based on a finding of 100% service-connected disability or receipt of a needs-based pension from VA as described in OAR 333-008-0020.

\$50 growsite registration fee

- If a designated grower is someone other than the patient, a \$50 growsite registration fee is required in addition to the application fee.



Before submitting, review the checklist on page 16 and delivery instructions on page 17.

Extensions

A patient may ask the OMMP to extend the expiration date of his/her cards if he/she is facing a personal hardship. An extension request is rare; however, the program will provide the patient one extension request within a three-year period as necessary. To request an extension, submit the Extension Request Form before your current registration expiration date. You can download the form from our website or call the OMMP to have one mailed to you.

In order for OMMP to grant you an extension, the extension request must be:

- Received by the OMMP on or before the date the current cards expire;
- Signed by the patient; and
- The only extension request granted to the patient in the last three years.



Received on or before current card expires



Oregon Medical Marijuana Program
PO Box 14450
Portland, OR 97293-0450
(971) 673-1234 (Mon – Fri, 9:00am - 4:00 pm)
www.healthoregon.org/ommp

Extension Request Form

- Please type or print legibly.
- The OMMP must receive this form **before** your current card expires to be eligible for an extension.
- The Patient may have **ONE** 30-day extension granted every 3 years.
- Extension Requests are processed at a priority level.
- You will receive a response in writing once your request has been processed.

Please type or print legibly.

PATIENT – REQUIRED	
LEGAL NAME (Last, First, MI):	DATE OF BIRTH:
MAILING ADDRESS:	PHONE:

Reason for Extension Request – REQUIRED

--

PATIENT SIGNATURE & DATE – REQUIRED

PATIENT SIGNATURE:	DATE:
--------------------	-------

Mail or fax completed request form to:



OHA/OMMP
PO Box 14450
Portland, OR 97293-0450
Fax: 971-673-1278

How to withdraw from the program

- A cardholder may withdraw from OMMP at any time by submitting a signed request.
- If a cardholder withdraws, it is the patient's responsibility to notify his/her caregiver and/or grower that his/her card(s) are no longer valid.
- The patient must return all cards to the OMMP within seven calendar days of the date you notified OMMP of the withdrawal.

For more information

To find more Oregon Medical Marijuana Program information including frequently asked questions, basic facts, statistics, forms and more information on rules and statutes, please visit our website: **www.oregonhealth.org/ommp**.



PUBLIC HEALTH
Oregon Medical Marijuana Program

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact Oregon Medical Marijuana Program (OMMP) at 971-673-1234 or 971-673-0372 for TTY.