

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.

Make sure the form is signed by the Patient.

Oregon Medical Marijuana Program
 PO Box 14450
 Portland, OR 97293-0450
 (971) 873-1234 (Mon - Fri, 9:00am - 4:00 pm)
www.health.oregon.gov/ommp

Office Use Only
 CHC GRA 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 SSI 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 1/20/14

Replacing a Caregiver 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.



Don't Forget! You must attach a copy of valid State or Federally issued Photo ID for a new Caregiver and/or Grower.

Adding New Caregiver or Grower:

If you are currently without a Caregiver and/or Grower/Growsite and need to add a new, check the **“Add new Caregiver”** and/or **“Add new Grower/Growsite”** box.