



**STATE OF MAINE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Medical Use of Marijuana Program  
Change Form**

<b>SECTION 1: Patient/Caregiver Information</b>				<b>Patient</b> <input type="checkbox"/>	<b>Caregiver</b> <input type="checkbox"/>
Legal Name:					
Date of Birth:		Driver's License No.:		Telephone No.: (     )	
Street Address:					
City:		State:	Zip:		County:
Email Address:					

<b>SECTION 2: Current Card Information</b>	
Current Registration # on Card: _____	Current Control # on Card: _____
Current Registration # on Card: _____	Current Control # on Card: _____
Current Registration # on Card: _____	Current Control # on Card: _____
Current Registration # on Card: _____	Current Control # on Card: _____
Current Registration # on Card: _____	Current Control # on Card: _____

*For questions regarding this program and/or application, please contact the following:*

Department of Health and Human Services  
Licensing and Regulatory Services  
Maine Medical Use of Marijuana Program  
41 Anthony Ave  
11 State House Station  
Augusta, ME 04333-0011

Tel: (207) 287-4325      Fax: (207) 287-2671      Toll Free: 1-800-791-4080      TTY users call Maine relay 711  
Email: [medmarijuana.dhhs@maine.gov](mailto:medmarijuana.dhhs@maine.gov)

<i>Office Use Only:</i>				
Check# _____	MO # _____	Amount \$ _____	Initials: _____	License# _____

**SECTION 3: Change Information**

Date change to take effect: \_\_\_\_\_

Check all that apply and complete the required information:

Current Information	New Information
<input type="checkbox"/> Change NAME from:	Change NAME to:
Change ADDRESS from: <input type="checkbox"/> Physical Address (No Fee)  <input type="checkbox"/> Mailing Address (\$10 Re-issue Fee-Per Card)  <input type="checkbox"/> Grow Location (No Fee)	Change ADDRESS to: _____  _____  _____
<input type="checkbox"/> Change DESIGNATED GROWER from: <input type="checkbox"/> Patient cultivation <input type="checkbox"/> Dispensary cultivation <input type="checkbox"/> Primary caregiver cultivation <input type="checkbox"/> Both patient and dispensary <input type="checkbox"/> Both patient and primary caregiver	Change DESIGNATED GROWER to: (\$10 Re-issue Fee) <input type="checkbox"/> Patient cultivation <input type="checkbox"/> Dispensary cultivation <input type="checkbox"/> Primary caregiver cultivation <input type="checkbox"/> Both patient and dispensary <input type="checkbox"/> Both patient and primary caregiver

**SECTION 4: Declaration**

- I UNDERSTAND and acknowledge my duties as a patient/caregiver.
- I DECLARE under penalty of perjury that the information provided on this form is true and correct.
- I CERTIFY that I will not sell, furnish or give marijuana to a person who is not allowed to possess marijuana for medical purposes, except as provided under the Maine Medical Use of Marijuana Act, and its rules.

\_\_\_\_\_  
Print name of patient/caregiver\_\_\_\_\_  
Signature of patient/caregiver\_\_\_\_\_  
Date\_\_\_\_\_  
Print name of person legally responsible\_\_\_\_\_  
Signature of person legally responsible\_\_\_\_\_  
Date