



STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Medical Use of Marijuana Program
 Change/Re-issue Form

| | | | | | |
|--|--|--------|---------------------------|------------------------------------|-----------------------------------|
| SECTION 1: Caregiver/Employee Information | | | | Caregiver <input type="checkbox"/> | Employee <input type="checkbox"/> |
| Legal Name: | | | | | |
| Date of Birth: | | | Telephone Number: () | | |
| Mailing Address: | | | | | |
| City: | | State: | Zip: | County: | |

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| SECTION 2: Replacement card information |
| Please indicate why you are requesting a replacement card: (\$8 Re-issue Fee-Per Card) |
| <input type="checkbox"/> Card was lost or stolen <input type="checkbox"/> Card was damaged |

Submit completed application and applicable fees to the following:

Department of Health and Human Services
 Maine Center for Disease Control and Prevention
 Maine Medical Use of Marijuana Program
 286 Water Street
 11 State House Station
 Augusta, ME 04333-0011

Tel: (207) 287-8016

Fax: (207) 287-2671

TTY users: Dial 711 (Maine relay)

Email: MMMP, DHHS DHHS.MMMP@maine.gov

Website: www.mainepublichealth.gov/mmm

| | | |
|------------------|-----------------|-----------------|
| Office Use Only: | | |
| Check/MO # _____ | Amount \$ _____ | Initials: _____ |

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 (\$8 Re-issue Fee-Per Card) <input type="checkbox"/> Grow Location (No Fee) | Change ADDRESS to: _____ _____ _____ |

SECTION 4: Fees**APPLICATION FOR REPLACEMENT CARD**

Please enclose the required fee of \$8.00 for each replacement card.

Make bank check or money order payable to "Treasurer, State of Maine".**We are unable to accept personal checks, cash and credit cards.****Total Bank Check/Money Order enclosed:**

\$ _____

\$ _____

SECTION 5: Declaration

I DECLARE under penalty of perjury that the information provided on this form is true and correct.

Print name of caregiver/employee_____
Signature of caregiver/employee_____
Date_____
Print name of person legally responsible_____
Signature of person legally responsible_____
Date