State of Rhode Island and Providence Plantations - Department of Health
Medical Marijuana Program Office of Health Professionals Regulation
Room 104 - 3 Capitol Hill, Providence, RI 02908-5097

COMPASSION CENTER STAFF CHANGE OF INFORMATION FORM

Office Use Only

Approved By:
Date of Approval:
ID #:

Provide changes to your registration information below. Check the box in the section that you wish to change. There is a twenty-five ($25.00) fee per form. Payable to the "General Treasurer, State of RI"

☐ **STAFF NAME OR ADDRESS CHANGES** ☐ **WITHDRAW FROM CENTER- NO FEE ($0)**

Full Name

Address

City State Zip Code –

Phone – E-Mail

Staff License Number

Name of Compassion Center

ATTESTATION SIGNATURE AND DATE

I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge. I understand that there is a twenty-five-dollar (**$25.00**) (NON-REFUNDABLE) fee **per form** for changes.

Checks or money orders must be made payable to the "General Treasurer, State of Rhode Island". I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use this "Compassion Center Staff Change of Information Form"), within ten (10) days of any changes to the information provided.

Staff Member Signature: Date of Signature:

This form is to be completed by the Center Staff and is for CHANGES to registration information or WITHDRAWAL only.

Revised 09/18/2013