IN ORDER TO ENSURE TIMELY DELIVERY AND AVOID UNEXPECTED DELAYS, PLEASE SEND IN YOUR COMPLETED APPLICATION BY REGULAR US MAIL.

INSTRUCTIONS
FOR CHANGE OF INFORMATION FORM

This form is to be used by **PATIENTS ONLY** who are already enrolled in the program for the following types of changes:

- Patient Name or Address Changes - Must be a Valid Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a RI Driver's License, RI State ID, vehicle registration, voters registration, correspondence from another state agency for benefits with a current date **Note: Your name and current address must appear on the document you submit as proof of residency. Name change requires a legal document (ie. Marriage Certificate, Divorce Decree).**

- Withdrawal from Medical Marijuana Program - Change in Debilitating Medical Condition (If you no longer have the debilitating medical condition that qualified you for inclusion in the Rhode Island Medical Marijuana Program you can withdraw from the program. If you withdraw, your registration card and the registration cards of your primary caregiver(s) will become null and void as soon as the Department of Health receives this form. You must also return your registry identification card to the Department of Health.

- Authorized Purchaser Name or Address Changes - (Authorized Purchasers that are already associated with you in the program. All changes of authorized purchasers information **must be provided by the patient.**) **Name change requires a legal document (ie. Marriage Certificate, Divorce Decree).**

- Caregiver(s) Name or Address Changes - (Caregivers that are already associated with you in the program. All changes of authorized purchaser information **must be provided by the patient.**) Must be a Rhode Island resident and must submit proof of residency. The following are acceptable documents: copy of a RI Driver's License, RI State ID, vehicle registration, voters registration, correspondence from another state agency for benefits with a current date. **Note: Your name and current address must appear on the document you submit as proof of residency. Name change requires a legal document (ie. Marriage Certificate, Divorce Decree).**

- Drop Caregiver or Authorized Purchaser

Completing the Form

1. Provide your name, medical marijuana registration number, date of birth and social security number on the form.
2. Check the box in the section that you would like to change and enter the new information; or indicate withdrawal from the program.
3. Sign, date and mail the completed form to the address listed at the top of the form with a check or money order in the amount of $10.00 payable to "General Treasurer, State of RI.
4. If changing patient or caregiver address you must also enclose proof of residency.
5. Please keep a copy of your forms. The Department does not make copies of forms for the public.

NOTE: Pursuant to RI General Laws there is a $10.00 fee charged for any changes of information. A $10.00 check or money order made payable to the "General Treasurer, State of Rhode Island" should accompany this form.

Adding New Caregiver or Authorzied Purchaser - DO NOT USE this Change form

If you wish to add a new caregiver please email doh.mmp@health.ri.gov or call 401-222-3752. A form to add a caregiver or authorized purchaser will be mailed to you.

State of Rhode Island and Providence Plantations - Department of Health
Center for Professional Licensing
Room 105A - 3 Capitol Hill, Providence, RI 02908-5097

CHANGE OF INFORMATION FORM

ALL CHANGES MUST BE SUBMITTED DIRECTLY FROM THE PATIENT

Office Use Only

Approved By:
Date of Approval:
ID #:

Patient Name (First, M.I., Last)

Medical Marijuana Registration Number

Date of Birth- MM/DD/YYYY

Provide changes to your registration information below. Check the box in the section that you wish to change. There is a ten ($10.00) fee per form. Payable to the "General Treasurer, State of RI"

☐ PATIENT NAME OR ADDRESS CHANGES - PROOF REQUIRED ☐ WITHDRAW FROM MARIJUANA PROGRAM - NO FEE ($0)

Full Name

Address

City State Zip Code –

Phone – E-Mail

☐ CAREGIVER NAME OR ADDRESS CHANGES - PROOF REQUIRED ☐ DROP CAREGIVER ☐ DROP PATIENT

Full Name

Address

City State Zip Code Date of Birth – –

Phone – E-Mail

☐ AUTHORIZED PURCHASER NAME OR ADDRESS CHANGES ☐ DROP AUTHORIZED PURCHASER ☐ DROP PATIENT

Full Name

Address

City State Zip Code Date of Birth – –

Phone – E-Mail

PATIENT'S 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 ten-dollar (**$10.00**) (NON-REFUNDABLE) fee **per form** for changes.

Checks or money orders must be made payable to the "General Treasurer, State of Rhode Island". If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete the form; attest to; and sign this statement. I also agree to notify the Department of Health, Center for Professional Licensing, Medical Marijuana Program, in writing (use this "Patient Information Change Request Form"), within ten (10) days of any changes to the information provided.

Signature: Date of Signature:

Proxy's Signature (if applicable): Date of Signature:

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