



COLORADO

Medical Marijuana Registry

Department of Public Health & Environment

CR

Change Request

Request online registration access:

1. Create your user account by visiting: medicalmarijuana.colorado.gov
2. Select "Request online registration access", complete the patient information section of this form and email the form and a copy of your valid Colorado driver's license or photo ID to medical.marijuana@state.co.us.
3. You will receive an email when your account information is available.

To request a replacement card:

1. Select "Request a replacement card", and complete the patient information section.
2. Include a copy of your valid Colorado driver's license or photo ID.

To change your name:

1. Select "Change my name", complete the patient information and change my name section.
2. Include copies of certified documentation such as a marriage certificate, divorce decree or other court documents to show your name change.
3. Include a copy of your valid Colorado driver's license or photo ID reflecting your new name.

To change your caregiver: (Caregivers must be registered and provide you with their caregiver registration ID).

1. Select "Change my caregiver", complete the patient information section and caregiver information section.
2. Include a copy of your valid Colorado driver's license or photo ID.

To surrender your card:

1. Select "Surrender my card", complete patient information and surrender my card section.
2. Include a copy of your valid Colorado driver's license or photo ID.
3. Include your medical marijuana registry card.

For patients under the age of 18:

The primary parent/legal guardian's signature is required on all forms for patients under the age of 18 along with a copy of the primary parent/legal guardian's valid Colorado driver's license or photo ID.

Please email your request to: medical.marijuana@state.co.us

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Change Request

This is a request to:

☐ Request online registration access☐ Receive a replacement card☐ Change my name☐ Surrender my card☐ Change my caregiver☐ Change my address**STAFF
ONLY**

Evaluated

Patient Information

Last Name		First Name	
Middle Initial		Date of Birth	
Patient Mailing Address			Apt/Ste #
City	State CO	Zip Code	County
Telephone	Email		
First 5 of SSN	Online User Name (if known)		

Change my name I have enclosed a copy of the certified, official document that proves my name change

New Name	Last Name	First Name	Middle Initial
Old Name	Last Name	First Name	Middle Initial

Change my Caregiver

This is a request to: <input type="checkbox"/> Add a caregiver <input type="checkbox"/> Remove my caregiver		
Caregiver Registration ID Number		
Caregiver Last Name	Caregiver First Name	Caregiver Date of Birth
What benefits do your caregiver and their products provide that improve your health and wellbeing?		

Request to Surrender I am requesting to terminate my right to possess and use medical marijuana

Card Status: <input type="checkbox"/> I have included my card with this form <input type="checkbox"/> I do not have my card	
I hereby certify that I, the patient, have verified the above information to be accurate and complete and no one other than me (or my legally authorized representative) is submitting this request on my behalf.	
Patient's or Authorized Representative's Signature:	Date