Medical Marijuana Program
MONTHLY REMITTANCE FORM
(Please Print)

Instructions: Within 30 calendar days after the end of the remittance month, please submit the following identification card activity information along with a check or money order for the California Department of Public Health's (CDPH) portion of the fees collected.

SECTION 1	**SECTION 2**
Name of county	Remittance period (month/year)

SECTION 3	**SECTION 4**	**SECTION 5**
Name of county contact	Telephone number ( )	E-mail address

SECTION 6

Total state fees collected for all approved applications for this remittance period (as reported on the attached CDPH Report "County Fee Report" for the comparable remittance period): $

SECTION 7 DENIED NEW APPLICATION FEES FOR THIS REMITTANCE PERIOD.

A. Number of full fees collected	B. Total amount $
C. Number of Medi-Cal fees collected	D. Total amount $

SECTION 8 DENIED RENEWAL APPLICATION FEES FOR THIS REMITTANCE PERIOD.

A. Number of full fees collected	B. Total amount $
C. Number of Medi-Cal fees collected	D. Total amount $

SECTION 9

Grand total amount submitted for this remittance period (sum of Sections 6, 7B, 7D, 8B, 8D)

$

SECTION 10

Printed name of county contact

Signature of county contact Date

Section 11

If you have questions, please contact the Medical Marijuana Program at (916) 552-8600. Please make check or money order payable to the California Department of Public Health and submit with this remittance form and completed CDPH report "County Fee Report" for the comparable remittance period to:

California Department of Public Health
Medical Marijuana Program
MS 5202
P.O. Box 997377
Sacramento, CA 95899-7377