Cannabis Control Commission
COMMONWEALTH OF MASSACHUSETTS

Medical Use of Marijuana Program: Patient Registration Information Update Form

This form is for use by patients registered with the Medical Use of Marijuana Program (Program) in order to update their registration information. This form is only for use by patients who registered with the Program using a paper registration form.

A patient must notify the Program after any change to the information that the patient submitted for registration (such as a change in the patient's name, address, or phone number), by submitting this Patient Registration Information Update Form.

Complete and mail in the attached form along with, if applicable, a copy of your new valid form of identification (ID) – and document proving your Massachusetts residency, if applicable.

After your Patient Registration Information Update Form has been processed by the Program, you will receive a notification regarding the status of your registration information update(s). If an email address was provided, you will receive a notification regarding the status of your registration information update(s) via email.

Completing the Form

The following information must be entered into the form in order for the Program to update your registration information:

- Registration number;
- First name; *and*
- Last name.

The following information may be updated with the Program by providing the updated information in the form:

- Name;
- Residential address;
- Mailing address;
- Telephone number;
- Email address;
- Gender;
- How you choose to be communicated with;
- Valid form of ID (and document proving your Massachusetts residency, if applicable).

If submitting a new valid form of ID:
If you are submitting a new valid form of ID, complete the "Valid Form of Identification" portion of Section A in the form.

If your address has also changed, complete the "Residential Address" portion of Section A in the form.

Complete all required sections of the form neatly and accurately. **Incomplete forms or forms that are not signed and dated, or are not readable, will not be processed and will be returned to the individual.**

Valid Form of ID

Valid forms of ID include:

- Massachusetts driver's license;
- Massachusetts ID card (with a photograph of yourself);
- U.S. passport and another document that proves your Massachusetts residence; *or*
- U.S. military ID and another document that proves your Massachusetts residence.

If submitting a driver's license or Massachusetts ID:
If you submit a driver's license or Massachusetts ID card as your new valid form of ID, the name and address that you provide to the Program must match the name and address on your driver's license or Massachusetts ID card.

If submitting a passport or U.S. military ID:
If you submit a passport or U.S. military ID as your new valid form of ID, you must also submit a document that proves your Massachusetts residency (as outlined below). Also, the name and address that you provide to the Program must match the name and address on the document that proves your Massachusetts residency.

Submit one of the following to prove your residency:

- Utility bill (gas, electric, telephone, cable, or heating oil), that is less than 60 days old and must contain your name and address;
- Current Massachusetts motor vehicle registration card with your current address;
- Tuition bill with a due date of less than six (6) months ago and addressed to your current address;
- Car insurance policy or bill that is dated less than 60 days old;
- Home mortgage, lease, or loan contracts dated within six (6) months of today with your name, address, and signature;
- Certified U.S. Marriage Certificate dated within the past six (6) months;
- Property tax or excise tax bill for the current year with your name and address;

- First-class mail dated less than 60 days old from any federal or state agency that displays your name and address; *or*
- Current Massachusetts-issued Professional License with your address.

Submitting Your Form

Mail your:

- Completed Patient Registration Information Update Form; *and*
- If applicable, **copy** of your valid form of ID (and document proving your Massachusetts residency)

To:

Cannabis Control Commission
Medical Use of Marijuana Program
101 Federal Street, 13th Floor
Boston, MA 02110

After your Patient Registration Information Update Form has been processed by the Program, you will receive a notification regarding the status of your registration information update(s). If an email address was provided, you will receive a notification regarding the status of your registration information update(s) via email.

Questions

Should you have questions about this form, please contact the Medical Use of Marijuana Program at 833-869-6820.

PATIENT REGISTRATION INFORMATION UPDATE FORM

(Please Print)

SECTION A: PATIENT INFORMATION (REQUIRED)

Your first name, last name, and registration number must be entered in this form. Other than your first name, last name, and registration number, only provide that information which you are updating.

If you are updating your name or address, the name and address you submit on this form must match the name and address on your valid form of identification, or your proof of primary residence, as provided to the Medical Use of Marijuana Program.

1. Registration Number:

2. Last name:

3. First name: Middle initial:

4. Phone number:
( )

5. Email address:

6. Gender:
☐ Male ☐ Female

7. I choose to be communicated with via: ☐ U.S. Mail ☐ E-Mail

RESIDENTIAL ADDRESS

8a. Residential address of patient:

8b. Residential address 2:

9. City:

10. State:

11. Zip Code:

MAILING ADDRESS
(IF DIFFERENT FROM RESIDENTIAL ADDRESS)

12a. Address 1:

12b. Address 2:

13. City:

14. State:

15. Zip Code:

VALID FORM OF IDENTIFICATION

Please note that if Passport or Military ID is selected, you will need to submit another document that proves your primary residence.

16. I am submitting a copy of the following valid form of identification:
☐ MA Driver's License ☐ MA ID Card ☐ US Passport ☐ US Military ID

17. Number on valid form of identification:

18. Expiration date of valid form of identification (mm/dd/yyyy):
/ /

SECTION B: PATIENT SIGNATURE (REQUIRED)

By signing below, I hereby certify that the above information is correct and complete.

19. Patient signature:

20. Date signed (mm/dd/yyyy):
/ /