Medical Cannabis Program

CHANGE OF INFORMATION FORM

*Within fourteen (14) calendar days of any change in a patient's name, address, caregiver, or recommending physician the patient who has been issued a registration identification card shall submit a completed change of information form.

*Within fourteen (14) calendar days of receiving notice of a patient's change of name, address, or recommending physician the patient's registered caregiver shall submit a written request for a new registration identification card using the change of information form.

INSTRUCTIONS: In the box at the top of the *Change of Information Form*, provide your name, date of birth, and registration number as it appears on your registration card. Check the box in the section that you would like to change and enter the new information as required.

FEES: There is no fee for the following changes:

- Change of patient or caregiver home address
- Remove caregiver registration
- Withdraw from the Medical Cannabis Program.

For all other changes, there is a $90.00 fee to replace the registration card. Registrants whose income is equal to or less than two hundred percent (200%) of the federal poverty level may replace their cards for a fee of $20.00. Fees may be paid by credit or debit card, check, certified check or cashier's check. Check must be made payable to the **DC Treasurer**.

SPECIFIC INSTRUCTIONS:

Name changes- if you have a name change, you must enclose a copy of your certificate of marriage, divorce decree, or court order which authorizes the name change.

Address changes- You must provide at least one primary source (original) document, as listed below, to satisfy proof of residency. Any one of the following documents will be accepted:

- Utility bill (Water, Gas, Electric, Oil, or Cable) with applicant name and address, issued within the last sixty (60) days
- Telephone bill (no cell phone, wireless or pager bills acceptable) reflecting applicant's name and current address, issued within the last sixty (60) days
- Deed or settlement agreement in applicant's name reflecting property address
- Unexpired lease or rental agreement with the name of the applicant listed as the lessee, permitted resident or renter (may be a photocopy)
- DC Property Tax bill
- Unexpired homeowner's insurance policy reflecting name and address
- Letter with picture from Court Services and Offender Supervision Agency (CSOSA) or DC Department of Corrections certifying name and residence
- DC DMV Proof of Residency Form signed by the person owning the residence AND a copy of this person's unexpired DC driver license or DC identification card AND one of the primary sources listed above (i.e. Utility bill, telephone bill, etc.) in the person owning the residence's name

Applicants can submit their application by emailing medicalcannabis@dc.gov, mail, or ABRA's Self-Service Kiosk located immediately outside ABRA's office doors.

Alcoholic Beverage and Cannabis Administration (ABCA):
899 North Capitol Street, NE, Suite 4200-A, Washington, DC 20002

CHANGE OF INFORMATION FORM

Name	Date of Birth	Registration Number

I am a: Patient ☐ Caregiver ☐

Change Name ☐	NEW Name (First, M.I., Last)
Remove Caregiver ☐	I no longer wish to be registered with my current caregiver. I understand that if I wish to designate a new person as my caregiver, that person must complete a Caregiver Application.
Change Address ☐ *(Complete NEW address information)*	Street (P.O. Boxes NOT acceptable) Apt/Suite City State Zip Code
Change Physician ☐ **New physicians must complete Physician Recommendation Forms*	NEW Physician's Name DC Medical License Number

_____ **Patients** (*initial*): I understand that I must notify ABRA in writing within 14 calendar days of any changes to my name, address, caregiver, or recommending physician. I shall submit the change of information form provided by ABRA; surrender my current registration identification card; notify my caregiver; pay the required fee; and will be issued a new card that reflects the changes. I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge.

_____ **Caregivers** (*initial*): I understand within 14 calendar days of receiving notice of a qualifying patient's change in name, address, or recommending physician. I shall submit the change of information form provided by ABRA; surrender my current registration identification card; pay the required fee; and will be issued a new card that reflects the changes. I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge.

Signature Date of Signature