MICHIGAN MARIJUANA REGULATORY AGENCY

Michigan Medical Marijuana Program
www.michigan.gov/mmp
(517) 284-6400

For Official Use Only
$40 Fee Required

Application Form for Registry Identification Card

To Apply or Renew Online Visit our website www.michigan.gov/mmp

DO NOT MAIL MORE THAN ONE APPLICATION PER ENVELOPE

Section A: Patient Information (NAME AS IT APPEARS ON ID) *(REQUIRED)*

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., etc.)

4. Patient Registry ID Card Number (For Renewals Only)	5. Date of Birth (MM/DD/YYYY)

6a. Mailing Address	6b. Apartment/Suite/Lot #

7. City	8. State	9. Zip Code
	MI	

10. Telephone Number (Optional)

Section B: Person Allowed to Possess Patient's Marijuana Plants *(REQUIRED)*

11. Plant possession: You must select one box. Failure to do so will result in the denial of your application.

SELECT ONLY ONE:

☐ I will possess the plants.

☐ My caregiver will possess the plants.

Section C: Caregiver Information (NAME AS IT APPEARS ON ID) *(If the patient is designating a caregiver)*

12. Legal First Name	13. Middle Initial	14a. Legal Last Name	14b. Suffix (Jr., Sr., etc.)

15. Caregiver Registry ID Card Number (For Renewals Only)	16. Date of Birth (MM/DD/YYYY)

17a. Mailing Address	17b. Apartment/Suite/Lot #

18. City	19. State	20. Zip Code

21. Telephone Number (Optional)

22. Other Names Used by Caregiver (Nicknames, maiden names, etc. Use a separate piece of paper if you need space for additional names.)

Section D: Patient /Caregiver Signature & Date *(REQUIRED)*

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 *et seq.*) and associated administrative rules. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution. I authorize the release of my protected health information, which includes the information contained in the form completed by my certifying physician, to the Michigan Medical Marijuana Program.

Signature of Patient: _____ **Date:** _____

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 *et seq.*) and associated administrative rules. I agree to serve as the patient's primary caregiver, am at least 21 years old, have no convictions that disqualify me from serving as a primary caregiver, and authorize the department to use the information provided in this application to perform a criminal background check. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution.

Signature of Caregiver: _____ **Date:** _____

RENEWAL WORKSHEET

Today's Date _____

Name _____ Date of Birth _____

Phone number _____

In what year did you first get your card? _____

Who was your certifying physician? _____

What was your qualifying condition? _____

_____ **Please initial to acknowledge that you have brought us all the records you can obtain from doctors who have cared for your qualifying condition.**

Please list any **procedures** or **surgeries** you have had in the last year:

_____

Please list any **new diagnoses** or **conditions** _____

Please list any **new medications** you are taking _____

_____

Please check the areas medical marijuana has helped you with in the last year:

__ *Sleep* __ *Appetite* __ *Pain relief* __ *Anxiety* __ *Nausea relief* __ *Reducing other medications*

Are there other improvements you'd like to tell us about? _____

Are you experiencing any negative side effects from marijuana? _____

Have you had any legal problems since we saw you? __ Y __ N

If yes, please explain _____

What modes of administration do you use (circle all that apply) *Smoke* *Vaporiser* *Edibles* *Topicals*

What strains work best? _____

How much do you use per week (estimate)? _____

When do you usually medicate? _____

Primary Care Provider Information

Name: _____ Phone: _____ Specialty: _____

Address: _____ _____ _____ _____

City State Zip Code

Do you want record of today's visit sent to your Primary Care Provider? Yes No

We want to keep on file for you any new medical records from your other doctor visits.
Please send medical records from any visits with other physicians over the past year, and during the next two years.

Patient Name: _____ **Date of Birth:** _____

General: Mark if you have had any of the following in the past 3 months

- ☐ Fever
- ☐ Weight Gain
- ☐ Chest Pain
- ☐ Chills
- ☐ Weight Loss
- ☐ Difficulty Breathing
- ☐ Night Sweats
- ☐ Marked Fatigue
- ☐ Nausea or vomiting
- ☐ Dizziness

Social History

- ☐ Smoker
- ☐ Other tobacco products
- ☐ Street Drugs (Other than Marijuana, strictly confidential)
- ☐ Alcohol _____ Daily _____ Weekly

Please mark diseases, symptoms or other items corresponding to your current and past health Problems:

Eyes, Ears, Nose, Throat

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss ☐ Left ☐ Right ☐ Both
- ☐ Frequent Ear Infections
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Eye Pain
- ☐ Other_____

Cardiovascular

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Angina
- ☐ Cardiac Arrhythmias
- ☐ Palpitations
- ☐ Pace Maker
- ☐ Stroke (Lasting deficits)
- ☐ TIA (Symptoms resolved completely)
- ☐ Peripheral Vascular Disease
- ☐ Other_____

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Pulmonary Embolism
- ☐ DVT (Blood Clot)
- ☐ Other Lung Problems_____

Integumentary

- ☐ Psoriasis
- ☐ Photosensitivity
- ☐ Skin Cancer
- ☐ Other Skin Problems_____

Gastrointestinal

- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ GERD
- ☐ Ulcers
- ☐ Heartburn
- ☐ Crohn's
- ☐ Colitis
- ☐ Cachexia or Wasting Syndrome
- ☐ Persistent Nausea
- ☐ Frequent Vomiting
- ☐ Blood in Stool
- ☐ Decreased Appetite
- ☐ Diverticulitis
- ☐ Other_____

Nervous System

- ☐ Migraine or other Headaches
- ☐ Nerve pain or Neuropathy
- ☐ Insomnia / Sleeping Disorder
- ☐ Parkinson's Disease
- ☐ Post Herpetic Neuralgia (Shingles pain)
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Severe and Chronic Pain
- ☐ Other_____

Renal

- ☐ Kidney Disease
- ☐ Require Dialysis
- ☐ Frequent Kidney Stones
- ☐ Other_____

Infectious Disease

- ☐ HIV/AIDS
- ☐ Hepatitis A B C
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ Other _____

Cancers

- ☐ Cancer : Type_____
- ☐ Cancer: Type_____
- ☐ Family History of Cancer diagnosed before age 50 yrs

***Are you currently or previously Treated with:*

- ☐ Chemotherapy
  Started:_____
  Duration:_____
  Treatments Per Week:_____
  End:_____

- ☐ Radiation Therapy
  Body Part:_____
  Start:_____
  Duration:_____
  End:_____

Metabolic/Endocrine

- ☐ Diabetes Type I or II (circle one)
- ☐ Thyroid Disorder
- ☐ Anemia
- ☐ Obesity
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Metabolic Syndrome
- ☐ Other:_____

Musculoskeletal

- ☐ Severe and Persistent Muscle Spasms
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Broken Bone: Where:_____
- ☐ Degenerative Disk Disease
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritis
- ☐ Fibromyalgia
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Bone Pain
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Other _____

Surgeries

- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Other bone/joint surgery
- ☐ Procedure to decrease pain:_____
- ☐ Injections to treat painful areas
- ☐ Transplant Surgery
- ☐ Abdominal Surgeries
- ☐ Heart Surgery
- ☐ Other Surgery or Procedure_____

Mental Health

- ☐ Panic Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ ADD/ADHD
- ☐ Suicidal thoughts, plans, or attempts
- ☐ History of abuse
- ☐ History of drug abuse
- ☐ Other_____

THIS SECTION FOR WOMEN ONLY:

- ☐ Could you be pregnant: YES NO
- ☐ Taking hormones
- ☐ Using oral contraceptive
- ☐ Pelvic Inflammation Disease
- ☐ Hysterectomy Full Partial Date:_____
- ☐ Ovaries Removed Date:_____
- ☐ Heavy Periods
- ☐ PMS or PMDD

- ☐ Trying to get pregnant YES NO
- ☐ Currently taking birth control
- ☐ Decreased Libido
- ☐ Hot Flashes
- ☐ Tubal Ligation Date:_____
- ☐ Natural Post Menopause Date of Last Period:_____
- ☐ Irregular Periods
- ☐ Other_____

THIS SECTION FOR MEN ONLY

- ☐ Decreased Libido
- ☐ Prostate Enlargement
- ☐ Problems Urinating
- ☐ Erectile Dysfunction
- ☐ Other _____

I certify that the above information is true and accurate to the best of my ability.

Signature (Required) _____ Date: _____

YOUR FOLLOW-UP CARE

Please call us within 30 days to inform us how the program is working for you. As always, our business staff is available 5 days a week to answer any questions you may have. You can also email us at ask@michiganholistichealth.com. We expect to provide follow-up care to you to monitor the efficacy of your medical use of marijuana.

As of April 1, 2013, the state is issuing two-year cards. However court cases in Michigan have held that a registry card—even one verified by the state-does not prove "ongoing" contact between the physician and patient.

For your protection, Michigan Holistic Health will need an annual appointment with you to maintain your doctor-patient relationship as required by the state. The charge for this annual appointment next year will be $75. We will review and assess your medical history and current medical conditions to determine that you are still likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat your condition. We will also discuss how well the program is working for you and offer recommendations for any additional care, such as alternative therapy.

_____ _____

Patient Name (please print) Date of birth

_____ _____

Patient signature Today's Date

THE PHYSICIAN MUST INITIAL EACH LINE BELOW:

I do hereby declare that the written certificate was prepared in the course of a bona fide physician-patient relationship in which each of the following were present as part of the treatment or counseling relationship:

____ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))

____ I have created and will maintain records of this patient's condition in accord with medically accepted standards.(MCL333.26423(a)(2))

____ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))

____ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's Primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition(MCL333.26423(a)(4))

"No marijuana-related legal action pending" Agreement

By signing below, I, _____, assert that

as of today, the _____ day of _____ in the year _____,

I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act's affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Michigan Holistic Health, PLLC at the time of service.

I also further assert that any and all information I give pertaining to my "qualifying condition" as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Michigan Holistic Health, PLLC harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Michigan Holistic Health PLLC – a Michigan Corporation.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____
Michigan Holistic Health, PLLC

Physician Release from all Liability Form

Signing this form releases the physicians of Michigan Holistic Health from all liability for providing a state of Michigan medical marijuana "Physician's Certification." And by signing this form, you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, the physicians of Michigan Holistic Health cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume nor can they, in any way, help or tell you how to acquire or grow it. Please consult the internet or your local compassion club.
3. The physicians of Michigan Holistic Health may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.
4. The physicians of Michigan Holistic Health cannot provide you with a regimen for the use of medical marijuana. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. Please take care if you have not used marijuana before. You are advised to keep a log of how much medicine you use and its effects on your symptoms. This will help you make adjustments to your dose and frequency.
6. You are in charge of the most comfortable and effective method of delivery – vaporizer, topicals, smoking or edibles. (It is not advisable for patients with lung issues or smoke allergies to smoke marijuana.) These are general guidelines and should be used in conjunction with your own common sense and wisdom about your health.
7. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.
8. Medical marijuana is generally tolerated well by patients. Any side effects tend to be mild and temporary, usually lasting one week or less as patients adjust. Common side effects include irritated throat, dry mouth, elevated heart rate, mild time and space disorientation, mild euphoria, a general sense of well-being, and in some instances drowsiness and amotivation.

I, _____, agree not to make any legal claim or complaint, or commence any proceeding against Michigan Holistic Health & Assoc. in providing me with a "Physician's Certification" as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form.

_____ _____

Signature of applicant Date

_____ _____

Signature of witness Date