



Medical Marijuana Program



165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
Fax: (860) 706-5361 • E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Change of Caregiver/Legal Guardian Form

INSTRUCTIONS:

When there has been a change in the name, address, telephone number or e-mail address of the primary caregiver or legal guardian, the qualifying patient must notify the Medical Marijuana Program within five (5) business days. Please complete all applicable sections below.

Section A: Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Registration Certificate Identification Number:	

Section B: Changes to Primary Caregiver

- | | | |
|--|--|---|
| <input type="checkbox"/> Add/Change caregiver* | <input type="checkbox"/> Address change | <input type="checkbox"/> Name change |
| <input type="checkbox"/> Phone number change | <input type="checkbox"/> E-mail address change | <input type="checkbox"/> Remove caregiver |

Section B: Reason for Change

- | | |
|--|--|
| <input type="checkbox"/> Caregiver no longer available | <input type="checkbox"/> Required: My medical condition has worsen/changed |
| <input type="checkbox"/> Caregiver no longer necessary | <input type="checkbox"/> Other: _____ |

Section C: Caregiver's Information

Previous Caregiver's Name or Address	Last Name:	First Name:	Middle Initial:
	Home Address (including Apartment or Suite #):		
	City:	State:	ZIP:
New Caregiver's Name or Address	Last Name:	First Name:	Middle Initial:
	Home Address (including Apartment or Suite #):		
	City:	State:	ZIP:
Supporting Documents	*Qualifying patients seeking to change their primary caregiver prior to the renewal of their registration certificate must request permission from the Department of Consumer Protection using this form. Once the request has been reviewed, the qualifying patient will be contacted by the department and provided additional instructions, if necessary.		



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Section D: Change of Caregiver's Phone Number or E-Mail Address:

Phone Number	Prior Phone Number:	New Phone Number:
E-Mail Address	Prior E-Mail Address:	New E-Mail Address:

Section E: Changes to Legal Guardian

- Add/Change Legal Guardian*
 Address Change
 Name Change
 Phone Number Change
 E-mail address Change
 Remove Legal Guardian

Previous Legal Guardian's Name or Address	Last Name:	First Name:	Middle Initial:
	Home Address (including Apartment or Suite #):		
	City:	State:	ZIP:
New Legal Guardian's Name or Address	Last Name:	First Name:	Middle Initial:
	Home Address (including Apartment or Suite #):		
	City:	State:	ZIP:
Supporting Documents	*New Legal Guardianship papers and Declaration of Person Responsible for the qualifying patient.		

Section F: Change of Legal Guardian's Phone Number or E-Mail Address:

Phone Number	Prior Phone Number:	New Phone Number:
E-Mail Address	Prior E-Mail Address:	New E-Mail Address:

I hereby certify that the above information is correct and complete.

I have reviewed this form and, to the best of my knowledge, it is accurate and complete. I certify under penalty of law (Connecticut General Statute Section 53a-157b) that the above information is the truth to the best of my knowledge.

I understand that the Department of Consumer Protection may contact me to confirm my change of information.

Signature: 	Date Signed:
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