LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Application Form for Registry Identification Card

(517) 284-6400 | www.michigan.gov/mmp

For Official Use Only MMP 3501 (Rev. 1/15)
□ $60 Patient (with no caregiver) Fee Received
□ $85 Patient (with caregiver) Fee Received

PRINT FORM

CLEAR FORM

Section A: Patient Information (REQUIRED) as it appears on your identication

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

4. Patient Registry ID Card Number (For Renewals Only)	5. MI Driver's License# or MI ID Card #	6. Date of Birth (MM/DD/YYYY)
P		

7a. Mailing Address	7b. Apartment/Suite/Lot #

8. City	9. State	10. Zip Code
	MI	

11. Email Address (If provided, you agree to receive email correspondence from MMMP)	12. Telephone Number

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

13. 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 (If the patient is designating a caregiver)

14. Legal First Name	15. Middle Initial	16a. Legal Last Name	16b. Suffix (Jr., Sr., III, etc.)

17. Caregiver Registry Card ID Number (For Renewals Only)	18. MI Driver's License# or MI ID Card #	19. Date of Birth (MM/DD/YYYY)
C		

20a. Mailing Address	20b. Apartment/Suite/Lot #

21. City	22. State	23. Zip Code
	MI	

24. Email Address (If provided, you agree to receive email correspondence from MMMP)	25. Telephone Number

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

Section D: Caregiver Patient 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.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Patient/Applicant: X _____ **Date:** _____

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

Appt. Time: _____	Date: _____			NEW	RENEWAL	NO MEDICAL RECORDS		
Cost of Service: $_____	Service :	$ 99	$135	$185	$210	$220	$245	
PAID WITH:	CASH ☐	CHECK ☐	CREDIT CARD ☐			Location:		

FREEDOM WELLNESS OF MICHIGAN, LLC
P.O. BOX 150017
Grand Rapids, MI 49515
616-419-3678

OFFICE NOTES: _____

CK IN _____ QUE CK _____ CK OUT _____

PATIENT GENERAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Apt #: _____ Date Of Birth: _____

City: _____ State: MI Zip: _____ Sex: Male ☐ Female ☐

Height: ____ft _____in Phone No.: _____ E-Mail: _____

Would you like to be added to our mailing list? Yes ☐ No ☐

Emergency Contact: Name: _____ Phone No. _____

How did you hear about Freedom Wellness. (please be specific).
Google Search ☐ Get Legal America ☐
Leafly ☐ Weed Maps ☐ MMMP Report ☐

Other: _____

PATIENT PRE-QUALIFICATION FOR THE MICHIGAN MEDICAL MARIJUANA PROGRAM

Is this your first visit to our clinic? Yes ☐ No ☐ If No, when? _____

Is this a NEW or RECERTIFICATION with MMMP? ☐ NEW RECERTIFICATION ☐

The following conditions are qualifications for the MMMP program.
Please select the condition(s) you are seeking qualifications for the MMMP program.

Amyotrophic Lateral Sclerosis: ☐	Glaucoma: ☐	Severe Nausea: ☐
Agitation of Alzheimer's: ☐	HIV/AIDS: ☐	Seizures: ☐
Arthritis: ☐	Multiple Sclerosis: ☐	Chronic Pain: ☐
Cachexia Disease: ☐	Nail Patella: ☐	Severe Pain: ☐
Crohn's Disease: ☐	Muscle spasms: ☐	Hepatitis C ☐
Cancer: ☐	Persistent Migraines: ☐	Post-Traumatic Stress Disorder ☐

Other _____

On a scale of 1 - 10, how would you rate the severity of your condition (when at it's worse): _____

How long have you been suffering from this condition? _____

Has a doctor diagnosed you with the condition? Yes ☐ No ☐

What is the name and address (city is fine) of the doctor(s) that you have seen for the condition(s)?

1 . _____

2 . _____

3. _____

PATIENT HISTORY OF CONDITION

Do you smoke Marijuana? Yes ☐ No ☐ Has Marijuana helped with your conditions(s)? Yes ☐ No ☐

Explain Marijuana use and results: _____

_____

Do you currently take prescription medication? Yes ☐ No ☐

Please list ALL medications that you are currently taking, including strength and dosage.

If you have a list already prepared, leave this area blank and submit your list to the doctor.

Medication Name	Strength & Dosage	Condition Used For

Are you allergic to any medications?

Do You Smoke Tobacco? Yes ☐ No ☐

Have you ever Smoked Tobacco? Yes ☐ No ☐ If Yes, Date:_____

I hereby certify, that all the information that I have provided on this form, is true and accurate.

_____ _____

Signature Date

PATIENT WAIVER AND CONSENT FORM

I _____, hereby authorize, your Doctor to evaluate me for my medical condition.
(Print your name here)

I understand that your Doctor will be conducting the evaluation in person and any information shared is private and confidential.

I understand that it is my responsibility to provide medical records, if available and also provide accurate information regarding my medical condition.

Providing information that is untruthful or inaccurate, is solely my responsibility, Freedom Wellness of Michigan, LLC and their Doctor, bear no liability regarding misinformation.

_____ _____
Your Signature Today's Date

LIABILITY WAIVER AND RELEASE

I _____, do hereby acknowledge that Freedom Wellness of Michigan, LLC and
(Print your name here) their Doctor are not liable,
nor can be held accountable;
for any action relating to or arising from my use or possession of marijuana. I further acknowledge that Freedom Wellness of Michigan, LLC and their Doctor, are not affiliated with the State of Michigan, Licensing And Regulatory Agency (LARA)

or the Michigan Medical Marihuana Program (MMMP) and that Freedom Wellness of Michigan, LLC and their Doctor cannot be held liable, should the LARA or the MMMP deny my application, for any reason whatsoever.

I further accept, understand and acknowledge that:

1. Freedom Wellness of Michigan, LLC is not a dispensary and cannot provide me with Medical Marijuana or any other medication.

2. That the Doctor's recommendation of Medical Marijuana is not a guarantee that it will cure or aid in the treatment of the condition it is intended for, and that I am solely responsible for taking Medical Marijuana.

3. I acknowledge that your Doctor has explained to me the purpose of Medical Marijuana, its benefits and side-effects. I have been given the opportunity to ask any questions or raise any concerns regarding the use of Medical Marijuana or its possible side-effects and that all my questions have been answered to my satisfaction.

_____ _____
Your Signature Today's Date

Doctor's Comments: _____

FREEDOM WELLNESS OF MICHIGAN, LLC
P.O. BOX 150017
Grand Rapids, MI 49515
616-419-3678

I, _____,

could not provide medical records today outside of past certifications.

I commit to doing any diagnostics that the doctor orders today and to return in 3 months for a check up with the doctor. ($36)

I understand that if I do not follow through that the doctor may call the state and revoke my card.

X_____

P.O. BOX 150017
Grand Rapids, MI 49515
616-419-3678

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____ Previous Name(s): _____

I request and authorize _____ at (_____) - _____ - _____
(My Doctor's Name/Hospital/ Facility) (my doctor's telephone/fax #)

to release healthcare information of the patient named above to:

FREEDOM WELLNESS OF MICHIGAN, LLC

P.O. BOX 150017
Grand Rapids, MI 49515

Main Office: **616-419-3678**
Fax:

Records Requested: _____

(the reason you're seeing our doctor)

The purpose of this request and the rules thereof are pursuant to: MMA333.26423(a)(1) and will expire 90 days from the date, authorized by signature, listed below.

Dates of Treatment: _____

☐ YES ☐ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative/positive, to the facility listed above. I understand that the facility listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES ☐ NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the facility listed above.

Patient's Signature: _____ Date: _____

The patient reserves the right to revoke this authorization at anytime thereafter, by submitting a written request, stating the reason for the revocation, as long as the patient submits the request in a timely manner, before the request has been carried out and the requested medical records have not been released.

FREEDOM WELLNESS

Patient Attestation & Pre-Exam Form

MMA333.26423(a)(1)(2)(3) EFFECTIVE APRIL 1, 2013 Act No. 512

Sec. 3. As used in this act:

(a) "Bona fide physician-patient relationship" means a treatment or counseling relationship between a physician and patient in which all of the following are present:

(1) The physician has reviewed the patient's relevant medical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of the patient.

(2) The physician has created and maintained records of the patient's condition in accord with medically accepted standards.

(3) The physician has a reasonable expectation that he or she will provide follow-up care to the patient to monitor the efficacy of the use of medical marihuana as a treatment of the patient's debilitating medical condition.

First Name: _____ Last Name: _____ Date Of Birth: _____

DEFINITION OF PAIN

Acute Pain: Pain associated with a illness, condition or injury, that is expected as a result of the condition.

Chronic Pain: Pain that last longer than expected due to an illness, condition or injury.

Persistent Pain: Pain that continues, even after the illness, condition or injury has healed. Usually due to scaring or inflammation, that is the result of the illness, condition or injury.

BY SIGNING THIS FORM, I AM AGREEING TO THE FOLLOWING:

1. I agree to return to this office in 3 months for a follow up visit to see the doctor.
2. I argee to will pay $35 for the office visit.
3. I acknowledge that if I do not show up for my follow up visit, the doctor reserves the right to contact the State of Michigan and have you removed from the program.

NOTE: THIS WILL NOT DELAY YOU RECEIVING YOUR CARD, WHICH SHOULD ARRIVE WITHIN 60 DAYS.

Patient Attestation

Please state "in your own words", your medical issues and using the diagram, circle the problem areas.

_____

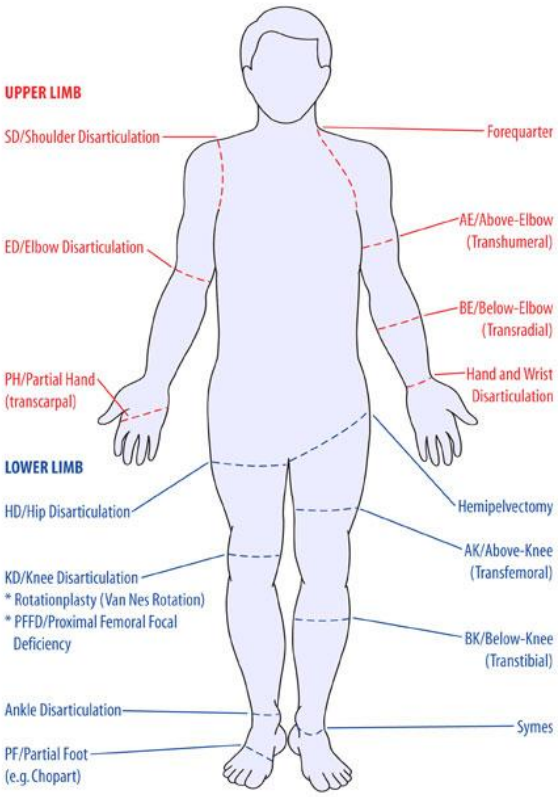
_____

_____

_____

_____

_____



Describe the results you've experienced from the medication(s) you've taken.

_____

_____

_____

_____