Medical Marijuana Use Registry Identification Card Application Instructions for Qualified Patients

In order to apply for a Medical Marijuana Use Registry Identification Card each patient must: be a Florida resident, be diagnosed with a qualifying condition, and must have been added to the Compassionate Use Registry (and received a Compassionate Use Registry Patient Identification Number) by a physician licensed under Chapter 458 or Chapter 459, Florida Statutes, to receive low-THC cannabis, medical cannabis, or a cannabis delivery device from an authorized Florida dispensing organization.

NEW PATIENT APPLICATIONS MUST INCLUDE ALL OF THE FOLLOWING

- A completed application. By providing your email address, you consent to the Department contacting you through the email address, including the provision of a temporary verification email.
- A copy of your Florida driver license or Florida identification card, or other proof of residency listed below
- A $75 check or money order (application fee) made out to Florida Department of Health.
- A full-face, passport-type 2x2 inches in size, color photograph taken within the 90 days immediately preceding application

  Minor applications must **also** include:

  - A designated legal representative and Medical Marijuana Use Registry Identification Card Legal Representative Application
  - A copy of the parent's or designated legal representative's proof of residency

PROOF OF RESIDENCY

Patients must submit a copy of a valid Florida driver license or Florida identification card. If the patient does not possess a valid Florida driver license or Florida identification card, they may submit a copy of a utility bill in the patients's name including a Florida address, or a Florida voter registration card. The name and address on the documents provided for residency must match the name and address in this application.

For minor patients, the parent or designated legal representative must submit proof of residency of the parent or designated legal representative.

RENEWAL APPLICATIONS

All Medical Marijuana Use Registry Identification Cards expire 1 year after the date of the physician's initial order. Submit renewal applications 45 days before your card expires. Renewal applications CANNOT be used to purchase low-THC cannabis, medical cannabis, or a cannbis delivery device.

LEGAL REPRESENTATIVE

If you are signing on behalf of the qualified patient in the application, you must provide proof of legal representation. A legal representative means the qualified patient's parent, legal guardian acting pursuant to a court's authorization as required under section 744.3215(4), Florida Statutes, health care surrogate acting pursuant to the qualified patient's written consent or a court's authorization as required under section 765.113, Florida Statutes, or an individual who is authorized under a power of attorney to make health care decisions on behalf of the qualified patient.

NOTICE ON THE COLLECTION, USE, OR RELEASE OF SOCIAL SECURITY NUMBERS

Florida law requires that public agencies provide individuals with a written statement identifying the state or federal law governing the collection, use, or release of social security numbers for each purpose for which the public agency collects an individual's social security number. The collection of social security numbers by the Florida Department of Health is either specifically authorized by law or imperative for the performance of the Florida Department of Health's duties and responsibilities as prescribed by law. This notice is provided pursuant to Subsection 119.071(5)(a), Florida Statutes. For the Compassionate Use Registry Identification Card Qualified Patient Application, social security numbers are collected and used for identification purposes to ensure that the number identifier assigned to the qualified patient is unique and matches the identity of the qualified patient, as authorized by sections 119.071(5)(a)2. and 119.071(5)(a)6., Florida Statutes. Social security numbers collected for this purpose will remain confidential.

KEEP THESE INSTRUCTIONS AND A COPY OF YOUR COMPLETED APPLICATION FOR FUTURE REFERENCE.

ELECTRONIC APPLICATION:

Expedite your application by applying online at

https://mmuregistry.flhealth.gov/

MAIL COMPLETED APPLICATION TO:

Office of Medical Marijuana Use
PO Box 31313
Tampa, FL 33631-3313

QUESTIONS?

Please call 800-808-9580 for assistance

Medical Marijuana Use Registry Patient Identification Card

Qualified Patient Application

☐ **Initial Application** ☐ **Renewal Application** ☐ **Minor Application**

Mail Completed Application to: Office of Medical Marijuana Use PO Box 31313 Tampa, FL 33631-3313	Patient Registry ID #:_____

Patient Information					
First Name		Last Name			Middle Initial
Date of Birth	Social Security Number		Address		
City	Apt/Ste #		State	Zip Code	County
Telephone	Email (optional to receive communication, including a temporary verification)				

Patient Passport Photo	
STAPLE 2"x 2" STAPLE STAPLE 2"x 2" STAPLE Attach a color photograph taken within 90 days of registration	Submit a full-face, passport-type, color photograph of the patient taken within the 90 days immediately preceding registration, and 2x2 inches in size. The image size measured from the bottom of your chin to the top of your head (including hair) should not be less than 1 inch, and not more than 1 3/8 inches. The photograph must be color, clear, with a full front view of your face, and printed on photo quality paper with a plain light (white or off-white) background. The photograph must be taken in normal street attire, without a hat, head covering, or dark glasses unless a signed statement is submitted by the applicant verifying the item is worn daily for religious purposes or a signed doctor's statement is submitted verifying the item is used daily for medical purposes. Headphones, "bluetooth", or similar devices must not be worn in the passport photograph. Any photograph retouched so that your appearance is changed is unacceptable. A snapshot, most vending machine prints, and magazine or full-length photographs are unacceptable.

Designate a Legal Representative *(if applicable)*		
Legal Representative First Name	Legal Representative Last Name	Legal Representative Date of Birth

I hereby certify the above information to be accurate and complete and no one other than me, or my legal representative, is submitting this request on my behalf.	
Patient or Legal Representative Name *(Print)*	
Patient or Legal Representative Signature	Date