



Oregon Medical Marijuana Program Change Form *(to be completed by patient)*
Please read the instructions provided on form [OHA 9241A](#) BEFORE filling out form.

Patient information *(required; type or print legibly)*

Name *(first, middle initial, last)*: _____ Date of birth: ____ / ____ / ____
Mailing address: _____ Gender: M F X
City: _____ State: _____ ZIP: _____ County: _____
Phone number: _____

Caregiver information *(complete only if you want to change or add a caregiver; check box if you want to remove)*

Remove caregiver
Name *(first, middle initial, last)*: _____ Date of birth: ____ / ____ / ____
Mailing address: _____ Gender: M F X
City: _____ State: _____ ZIP: _____ County: _____
Phone number: _____
Government-issued photo ID number *(enclose a copy)*: _____

Grower information *(complete only if you want to change or add a grower; check box if you want to remove)*

Remove grower *(if removing grower you must also remove the grow site)*
Name *(first, middle initial, last)*: _____ Date of birth: ____ / ____ / ____
Mailing address: _____ Gender: M F X
City: _____ State: _____ ZIP: _____ County: _____
Phone number: _____
Government-issued photo ID number *(enclose a copy)*: _____

Grow site information *(Must be physical address. Please see instructions for exceptions.)*

Remove grow site *(if removing grow site you must also remove the grower)*
Physical grow site address: _____
City: _____ State: **OR** ZIP: _____ County: _____
Grow site address zoning *(check one and enclose a copy if requested)*:
 Outside city limits Within city limits *(enclose zoning documentation)*

You must answer all of the following questions if you designated a grower/grow site.

Failure to answer all of the questions will result in your application being INCOMPLETE.

- Yes No Are you *(the patient)* your own grower?
 Yes No Is your caregiver your grower?
 Yes No Is the grow site your *(the patient's)* residence? *(Grow sites at patient's residence may have lower plant limits. Please see application instructions.)*
 Yes No Will the grower be transferring medical marijuana to a dispensary or processing site?
 Yes No Does the grow site have more than 12 mature medical marijuana plants?

Patient signature *(required)* — I testify the above information is true and I understand my application or cards may be denied, suspended or revoked for submitting false information.

Patient signature: _____ Date: _____

FEES MAY APPLY *(see back of form for replacement card and grow site registration fee information)*

Replacement card fees

- If you do not submit a complete change form or the correct replacement card fee, no changes will be made.
- There is no fee to change a mailing address or remove a caregiver or grower and grow site.

Patient replacement card fee: \$100 unless patient sends proof of:

Discounted fees	\$20	Supplemental Security Income (SSI). <i>(Note: Social Security Disability Income and retirement benefits do not qualify.)</i>
	\$20	Having served in the U.S. armed forces.

Grow site registration fee:

\$200	The grower must submit a \$200 grow site registration fee if one or more of the following is true: <ul style="list-style-type: none"> • The grow site is not the patient's residence. • The grower is not the patient on this form. • The grow site has more than 12 mature medical marijuana plants.
\$0	No grow site registration fee is required for patients growing for themselves at their own residence where there are 12 or fewer mature medical marijuana plants.

OMMP fees are non-refundable. Make checks payable to OHA/OMMP. Do not send cash. Growers may pay online after receiving notification from OMMP with payment instructions.

Mail change form, ID copies, residency proof, zoning documentation as applicable, and check/money order to:
OHA/OMMP, P.O. Box 14450, Portland, OR 97293-0450