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PUBLIC HEALTH DIVISION
Oregon Medical Marijuana Program

Oregon Health Authority

Oregon Medical Marijuana Program Change Form *(to be completed by patient)*

Sections 1 and 4 are required for all applicants. Be sure to sign section 4.

Section 1: Patient information *(Section 1 is required)*

Name (*first, middle initial, last*): _____ Date of birth: / /

Mailing address: _____ Gender: ☐ M ☐ F ☐ X

City: _____ State: _____ ZIP: _____ County: _____

Phone number:

Section 2: Primary 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*): _____

Organizational or facility caregiver information *(see instructions for details)*

☐ Remove organizational caregiver ☐ Add organizational caregiver

Section 3: Grower and grow site 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)*

Grower's 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 a 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: _____ ZIP: _____ County: _____

Grow site questions

1. Is the grow site inside city limits? ☐ Yes ☐ No
2. Is the grow site the patient's residence? *(Grow sites at a patient's residence may have lower plant limits. See instructions for details.)* ☐ Yes ☐ No
3. Will the grower be transferring medical marijuana to a medical marijuana dispensary or processing site? ☐ Yes ☐ No
4. Who is the owner of the property where the grow site is located? ☐ Patient ☐ Grower ☐ Other

(If "Other" is checked you are required to submit the Medical Marijuana Grow Site Consent form with this application.)

Section 4: Patient signature and fees *(section 4 is required)*

Patient signature

I attest the information provided is true and I understand my cards may be suspended or revoked for submitting false information. In addition, by signing I authorize OMMP to verify any information provided in this change form including but not limited to contacting the property owner providing consent for use of the grow site.

Patient signature: _____ **Date:** _____