## Change, Replacement or Surrender Request Instructions

In order to change, replace or surrender your Medical Marijuana Use Registry Identification Card, complete the Cardholder Information section and applicable section(s) of this form. By providing your email address, you consent to the Department contacting you through that email address.

To request a replacement card in the event of damage/loss/theft or change address:

- Complete section A of this form
- Include a copy of your Florida driver license, Florida identification card, or other valid proof of residency as established in section 381.986(5)(b), Florida Statutes.


## To change your name :

- Complete section B of this form
- Include a copy of your Florida driver license, Florida identification card, or a copy of your marriage certificate, divorce decree or other court document to show your name change.


## To change your caregiver:

To remove your caregiver

- Complete section C of this form

To change or add a caregiver

- Complete section C of this form
- Have your new caregiver complete a Medical Marijuana Use Registry Identification Card Caregiver Application
If a legal representative is signing on behalf of the patient to change or add a caregiver, the legal representative must provide proof of legal representation as stated in DH8009-OCU-03/2018, "Medical Marijuana Use Registry Identification Card Qualified Patient Application."
NOTE: Replacement, name or address change, and caregiver change cards will require the submission of this form, along with a $\$ 15$ check or money order (application fee) made out to Florida Department of Health.


## To surrender your card:

- Complete section D of this form
- Include your Medical Marijuana Use Registry Identification card

For minor patients: The parent or legal guardian's signature is required on all forms for minor patients, along with a copy of the parent or legal guardian's Florida driver license or Florida identification card.

MAIL COMPLETED REQUEST TO:<br>Office of Medical Marijuana Use<br>PO Box 31313<br>Tampa, FL 33631-3313

## FIDAIDA DEPARTMENT OF HEALH Office of MedicalMarituana Use

## Change, Replacement or Surrender Request

Mail Completed Request to:
Office of Medical Marijuana Use PO Box 31313
Tampa, FL 33631-3313

| $\square$ Patient | $\square \quad$ Caregiver |
| :---: | :---: |
| Patient Registry ID \#: |  |

This is a request to:
$\square$ Receive a replacement card
$\square$ Change, add, or remove a caregiver
$\square$ Change my name
$\square$ Change my address
$\square$ Surrender my card

| Cardholder Information The address below is where the card will be mailed |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- |
| First Name | Sast Name | Middle Initial |  |  |  |
| Date of Birth | Social Security Number | Address (new address if applicable) |  |  |  |
| City | Apt/Ste \# | State | Zip Code | County |  |
| Telephone | Email (optional to receive communication by email) |  |  |  |  |


| A. Request a Replacement Card |  |  |  |
| :--- | :--- | :--- | :--- |
| Card Number (if known): | Date of Damage/loss/theft: <br> (if applicable) |  |  |
| Reason for replacement: | $\square$ New address | $\square$ Damaged $\quad \square$ Lost $\quad \square$ Stolen |  |

B. Name Change (Include a copy of the document that proves name change)

| New Name | First Name | Last Name | Middle Initial |
| :--- | :--- | :--- | :--- |
| Old Name | First Name | Last Name | Middle Initial |

C. Change, add, or remove caregiver

Change my caregiver $\quad \square$ Add caregiver $\square$ Remove my caregiver

| Current | First Name | Last Name | Middle Initial |
| :--- | :--- | :--- | :--- |
| New | First Name | Last Name | Middle Initial |


| D. Request to Surrender |  |  |  |
| :--- | :---: | :---: | :---: |
| Card status: | $\square$ I have included my card | $\square$ I have not included my card |  |

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 |
| :--- | :--- |

## 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 Change, Replacement or Surrender Request, social security numbers are collected and used for identification purposes to ensure that the number identifiers match the identities of the cardholder, 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.

