Government of the District of Columbia
Department of Health
Health Regulation & Licensing Administration

CHANGE OF INFORMATION FORM

*Within fourteen (14) calendar days of any change in a patient's name, address, caregiver, recommending physician, or designated dispensary, the patient who has been issued a registration identification card shall submit a completed change of information form.

*Within fourteen (14) calendar days of receiving notice of a patient's change of name, address, recommending physician, or designated dispensary, the patient's registered caregiver shall submit a written request for a new registration identification card using the change of information form.

INSTRUCTIONS: In the box at the top of the *Change of Information Form*, provide your name, date of birth, and registration number as it appears on your registration card. Check the box in the section that you would like to change and enter the new information as required.

FEES: There is no fee to remove caregiver registration or withdrawal from the Medical Marijuana Program. For all other changes, there is a $90.00 fee to replace the registration card. Registrants whose income is equal to or less than two hundred percent (200%) of the federal poverty level may replace their cards for a fee of $20.00. Fees may be paid by certified check, money order, or cashier's check payable to the **DC Treasurer**; no personal checks.

SPECIFIC INSTRUCTIONS:

Name changes- if you have a name change, you must enclose a copy of your certificate of marriage, divorce decree, or court order which authorizes the name change.

Address changes- You must provide at least one primary source (original) document, as listed below, to satisfy proof of residency. Any one of the following documents will be accepted:

- Utility bill (Water, Gas, Electric, Oil, or Cable) with applicant name and address, issued within the last sixty (60) days
- Telephone bill (no cell phone, wireless or pager bills acceptable) reflecting applicant's name and current address, issued within the last sixty (60) days
- Deed or settlement agreement in applicant's name reflecting property address
- Unexpired lease or rental agreement with the name of the applicant listed as the lessee, permitted resident or renter (may be a photocopy)
- DC Property Tax bill
- Unexpired homeowner's insurance policy reflecting name and address
- Letter with picture from Court Services and Offender Supervision Agency (CSOSA) or DC Department of Corrections certifying name and residence
- DC DMV Proof of Residency Form signed by the person owning the residence AND a copy of this person's unexpired DC driver license or DC identification card AND one of the primary sources listed above (i.e. Utility bill, telephone bill, etc.) in the person owning the residence's name

Mail completed forms to: DC Department of Health
899 North Capitol Street NE, 2nd Floor
Washington, DC 20002

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_____ _____ _____
Name Date of Birth Registration Number

I am a: ☐ patient ☐ caregiver

☐ **Change name**	_____ NEW Name (First, M.I., Last)
☐ **Remove caregiver**	I no longer wish to be registered with my current caregiver. I understand that if I wish to designate a new person as my caregiver, that person must complete a Caregiver Application.
☐ **Change address** *(Complete NEW address information)*	_____ Street (P.O. Boxes NOT acceptable) Apt/Suite _____ _____ _____ City State Zip Code
☐ **Change Dispensary** **Card must be issued by DOH prior to changing dispensaries*	_____ Name of NEW Dispensary _____ Street Zip Code
☐ **Change Physician** **New physicians must complete Physician Recommendation Forms*	_____ _____ NEW Physician's Name DC Medical License Number

_____ **Patients** (*initial*): I understand that I must notify the Department of Health in writing within 14 calendar days of any changes to my name, address, caregiver, recommending physician, or designated dispensary. I shall submit the change of information form provided by the Department; surrender my current registration identification card; notify my caregiver; pay the required fee; and will be issued a new card that reflects the changes. I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge.

_____ **Caregivers** (*initial*): I understand within 14 calendar days of receiving notice of a qualifying patient's change in name, address, recommending physician, or designated dispensary, I shall submit the change of information form provided by the Department; surrender my current registration identification card; pay the required fee; and will be issued a new card that reflects the changes. I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge.

_____ _____
Signature Date of Signature