



Government of the District of Columbia
Department of Health



Health Regulation and Licensing
Administration
Medical Marijuana Program

REGISTRATION CARD REPLACEMENT FORM

In the event that a patient or caregiver experiences the theft, loss, or destruction of their registration card, they must submit a "Registration Card Replacement Form" within (72) hours after the initial discovery.

<input type="checkbox"/> Patient	Name _____	Date of Birth _____
<input type="checkbox"/> Caregiver	Registration Number (if known) _____	
Reason for Card Replacement (check one)	<input type="checkbox"/> Card was lost <input type="checkbox"/> Card was destroyed <input type="checkbox"/> Card was stolenDate Stolen: _____ <input type="checkbox"/> Other (<i>specify</i>) _____	
Replacement Fee Fees may be paid by certified check, money order, or cashier's check payable to the DC Treasurer ; no personal checks.	<input type="checkbox"/> \$90.00 <input type="checkbox"/> \$20.00 for patients or caregivers whose income is equal to or less than two hundred percent (200%) of the federal poverty level <u>In verifying income for reduced fees, applicants must submit proof of the following:</u> <ul style="list-style-type: none"> • Proof of being a current Medicaid or DC Alliance recipient; or • Documentation verifying that the applicant's total gross income, including child support payments, alimony and rent payments received and any other income received on a regular basis, is equal to or less that 200% of the federal poverty level, as defined by the US Department of Health and Human Services. <u><i>In verifying income for the purposes of this qualification, an individual may submit the following:</i></u> <ul style="list-style-type: none"> • Earnings statements received within the previous thirty (30) days • District of Columbia or Federal tax filing returns for the most recent tax year; • For newly employed applicants, a verifiable copy of an offer of employment that states the amount of salary to be paid; • A copy of a Social Security or worker's compensation benefit statement; • Proof of child support or alimony received; • Any other unearned income or assets, including but not limited to, stocks, bonds, annuities, private pension and retirement accounts; or • Any other item(s) of proof deemed by the Director of the Department of Health or the Director's agent reasonably calculated to demonstrate a person's current income. 	

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

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