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.

Patient Caregiver	Name ______________________ Date of Birth ______________ Registration Number (if known) ______________________________
Reason for Card Replacement (check one)	Card was lost Card was destroyed Card was stolen ....Date Stolen: ________________ Other (*specify*) ______________________________
Replacement Fee Fees may be paid by certified check, money order, or cashier's check payable to the **DC Treasurer**; No personal checks.	☐ $90.00 ☐ $20.00 for patients or caregivers whose income is equal to or less than two hundred percent (200%) of the federal poverty level In verifying income for reduced fees, applicants must submit proof of the following: 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. ***In verifying income for the purposes of this qualification, an individual may submit the following:*** 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 and fees to: **DOH – Medical Marijuana, P.O. Box 37804, Washington D.C. 20013**