

**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	<u>Name</u> _____	<u>Date of Birth</u> _____
<input type="checkbox"/> Caregiver	<u>Registration Number (if known)</u> _____	
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. <p style="margin-left: 20px;"><u><i>In verifying income for the purposes of this qualification, an individual may submit the following:</i></u></p> <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 and fees to: **DOH – Medical Marijuana, P.O. Box 37804, Washington D.C. 20013**