



# Medical Marijuana Program

450 Columbus Boulevard, Suite 901, Hartford, CT 06103-1840 • (860) 713-6066  
Fax: (860) 706-5361 • E-mail: [dcp.mmp@ct.gov](mailto:dcp.mmp@ct.gov) • Website: [www.ct.gov/dcp/mmp](http://www.ct.gov/dcp/mmp)



## Change of Records Form Instructions

**Please Note:** A qualifying patient or primary caregiver must report any changes in their application within five (5) business days of such change.

1. You may use this form to notify the Department of a change of:
  - a. Name
  - b. Home Address
  - c. Phone Number
  - d. Email Address
2. Please type or neatly print all required sections of the form.
3. After completing the form, you must sign and date it.
4. Please be aware that you may be contacted by the Department to confirm your change of information.
5. In addition to this form, you must provide the Department with the following supporting documentation to verify your change of information.

Changed Information	Required Documents in addition to this Change of Information Form
Name	Certified document showing name change (i.e. marriage license, civil union certificate, divorce decree, probate court document)
Address	One document from the list below, showing your name and new address: <ul style="list-style-type: none"> <li>• Computer-generated bill from a bank or mortgage company, utility company, doctor or hospital</li> <li>• Pre-printed pay stub showing your employer's name and address</li> <li>• W-2 form property or excise tax bill, or Social Security Administration or other pension or retirement annual benefits summary statement and dated within the current or prior year</li> <li>• Medicaid or Medicare benefit statement</li> <li>• Current valid homeowner's, renter's or motor vehicle insurance policy dated within the last year</li> <li>• Current motor vehicle loan statement for a motor vehicle registered in your name</li> <li>• Residential mortgage or similar loan contract, lease or rental contract showing signatures from all parties needed to execute the agreement and dated within the last year</li> <li>• First-class mail addressed to your home address</li> <li>• Connecticut voter registration card</li> <li>• Survey of your Connecticut property issued by a licensed surveyor</li> <li>• Connecticut handgun permit</li> <li>• Official school records showing current enrollment</li> <li>• Motor vehicle registration</li> </ul>
Phone Number	Form only
Email Address	Form only

6. Please mail, e-mail or fax this form and any supporting documentation to the Department of Consumer Protection, Attention Medical Marijuana Program, at the above addresses.



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## Change of Records Form

### Current Information as Shown on your Medical Marijuana Identification Card

I am a:  Patient  Caregiver

Last Name:	First Name:
Date of Birth:	Patient or Caregiver ID number (from your card):

### Change Request:

- Please check all changes that apply.
- For each option selected, complete all blanks in the corresponding portion of this form.

Change of name  Change of address  Change of phone number or e-mail address

### Change of Name:

<b>New Name</b>	Last Name:	First Name:	Middle Initial:
<b>Supporting Documents</b>	I have included a copy of the following certified document to prove my name change: <input type="checkbox"/> Marriage License <input type="checkbox"/> Civil Union Certificate <input type="checkbox"/> Divorce Decree <input type="checkbox"/> Probate Court Document		

### Change of Address:

<b>Old Address</b>	Home Address (including Apartment or Suite #):		
	City:	State:	ZIP:
<b>New Address</b>	Home Address (including Apartment or Suite #):		
	City:	State:	ZIP:
<b>Supporting Documents</b>	Please be sure to include two documents from the list on page 1 of this form, showing your new address. <b>(Patient only)</b>		


### Change of Phone Number or E-Mail Address:

<b>Phone Number</b>	Prior Phone Number:	New Phone Number:
<b>E-Mail Address</b>	Prior E-Mail Address:	New E-Mail Address:

### Certification:

I have reviewed this form and, to the best of my knowledge, it is accurate and complete. I certify under penalty of law (Connecticut General Statute Section 53a-157b) that the above information is the truth to the best of my knowledge.

I understand that the Department of Consumer Protection may contact me to confirm my change of information.

Signature: 	Date Signed:
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