OFFICE OF CANNABIS POLICY
DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES

Maine Medical Use of Cannabis Program
Caregiver Change / Reissue Form

Section 1: Registrant Information. Complete information as on current registration.			
Registrant's Legal Name:	Registry Identification Number: **CGR**		
Date of Birth:	Telephone Number:		
Mailing Address:	City:	State:	Zip:

Section 2: Type of Request. Check each type of change requested and complete the corresponding Section(s).

☐ Card was lost, stolen or damaged. If no changes, skip to Section 7.

☐ Change(s) to identifying or contact information, complete Section 3.

☐ Change(s) to registered caregiver authorized activities, complete Section 4. (If adding cultivation, also complete Section 6)

☐ Change(s) to location(s) of authorized activities, complete Section 5.

☐ Change to plant count, complete Section 6.

All registrants must complete Sections 7, 8 and 9.

Section 3: Identifying or Contact Information. Complete only those items that have changed.			
Registrant's Legal Name: *Please provide proof of legal name change, such as a marriage certificate, probate court order, or similar legal document.			
Trade Name/ DBA:	Website:		
Phone:	Email Address:		
Mailing Address:	City:	State:	Zip:
Residential Street Address:	City:	State:	Zip:

Section 4: Registered Caregiver Authorized Activities. Check those activities being added or removed.	
☐ Add ☐ Remove	Cultivation activities. *If adding, provide copy of pesticide applicator's license or check here if not applicable: ☐
☐ Add ☐ Remove	Manufacturing of cannabis without the use of inherently hazardous substance extraction.
☐ Add ☐ Remove	Manufacturing of cannabis using inherently hazardous substance extraction. *If adding, provide an Inherently Hazardous Substances Manufacturing Facility Registration Certificate Application.
☐ Add ☐ Remove	Manufacturing edible cannabis products. *If adding, provide copy of Commercial or Home Food License.
☐ Add ☐ Remove	Transfer, donation and/or sale of medical cannabis, concentrate and products to patients.
☐ Add ☐ Remove	Operation of one caregiver retail store. *If adding, provide copy of Retail Food Establishment License, if selling edible cannabis products, or check here if not applicable: ☐ AND provide Caregiver Retail Store Local Authorization Form completed by municipality where retail store is to be located.
☐ Add ☐ Remove	Purchase or other receipt of wholesale cannabis from other caregivers or dispensaries.
☐ Add ☐ Remove	Sale or other transfer of wholesale cannabis to other caregivers or dispensaries.

Section 5: Location(s). Complete only those items that have changed.			
Section 5a: Cultivation Location(s).			
Street Address:	City:	State:	Zip:
Is this location for: ☐ Mature Plants and/or ☐ Immature Plants	At this location, are you cultivating: ☐ Indoors and/or ☐ Outdoors		
Property Owner Name (if caregiver, put "Self"):	Property Owner Phone Number:		
Do you transfer to patients at this address? ☐ Yes ☐ No			
Street Address:	City:	State:	Zip:
Is this location for: ☐ Mature Plants and/or ☐ Immature Plants	At this location, are you cultivating: ☐ Indoors and/or ☐ Outdoors		
Property Owner Name (if caregiver, put "Self"):	Property Owner Phone Number:		
Do you transfer to patients at this address? ☐ Yes ☐ No			
Section 5b. Manufacturing Location.			
Street Address:	City:	State:	Zip:
Property Owner Name (if caregiver, put "Self"):	Property Owner Phone Number:		
Do you transfer to patients at this address? ☐ Yes ☐ No			
Section 5c. Caregiver Retail Store Location.			
Street Address:	City:	State:	Zip:
Property Owner Name (if caregiver, put "Self"):	Property Owner Phone Number:		
Section 5d. Caregiver Wholesale Storage Location.			
Street Address:	City:	State:	Zip:
Property Owner Name (if caregiver, put "Self"):	Property Owner Phone Number:		
Do you transfer to patients at this address? ☐ Yes ☐ No			

Section 6: Cultivation Plant Count. Complete only if changing plant count level or adding cultivation activities.

Caregiver cultivating:
(Select either a plant count or canopy)

Plants	**Annual Fee**
☐ 6 mature / 12 immature plants	$240
☐ 12 mature / 24 immature plants	$480
☐ 18 mature / 36 immature plants	$720
☐ 24 mature / 48 immature plants	$960
☐ 30 mature / 60 immature plants	$1,200

Canopy

☐ 500 Sq. Ft. Mature Canopy / 1,000 Sq. Ft. Immature Plant Canopy	$1,500

Section 7: Supplemental Documents.

☐ If you have not previously provided one to the Department, a 2"x2" photo with a clear image of applicant's face. Do not use filters commonly used on social media. Do not digitally change your photo. Use plain white or off-white background. A high-resolution photo that is not blurry, grainy, or pixelated.

☐ Business organization documents. If any of the documents required in Section 4 are issued in a business name, please provide the following:

If the business entity is a corporation, a copy of its bylaws and/or operating agreement and stock ledger; or
If the business entity is a limited liability company, a copy of its LLC agreement and/or operating agreement; or
If the business entity is any type of partnership, a copy of the partnership agreement.

Section 8: Fees. This change request will not be considered until the reissuance fee is remitted, if appliable.

All reissuances of a lost, stolen or damaged card, and the following changes require that the Registered Caregiver Identification Card and/or certificate of authorized activities be re-issued and therefore a reissuance fee is to be paid:

- Change in legal name of the individual registered caregiver.
- Change to trade name/DBA.
- Change to registered caregiver authorized activities.
- Change to location of any authorized activities.
- Change to plant count.

☐ This change request does not include one of the above changes, therefore a reissuance fee is not required.

Reissuance Fee: **$10.00**

Modification of Annual Fee: **$** _____ (Take the new plant count fee and subtract from prior annual fee for amount due.)

Total Fee Due: **$**

Cash and personal checks are <u>not</u> accepted by the Office of Cannabis Policy. Please submit a bank/cashier's check or money order made payable to "Treasurer, State of Maine." Include your name and license number on the payment.

All fees are non-refundable.

Section 9: Signature.

I understand and agree to provide documents, if requested, to clarify or support information provided in this change request and supporting documents. I understand and agree that federal, state and local officials or other persons and organization may verify the information I have given, except as limited by the confidentiality provisions of 22 MRS § 2425-A. Additionally, I affirm that if I have given incorrect or incomplete information in this change request, my individual registration card may be revoked. I understand the questions and requirements of this application and the consequences of providing inaccurate, incomplete, or falsified information in this application and attachments hereto. I certify that all answers and supporting information provided in this application are true, accurate and complete to the best of my abilities and knowledge.

Signature:	Date:
Printed Name:	