



State of Vermont
Medical Cannabis Program
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Cannabis Control Board

CARDHOLDER CHANGE/REQUEST FORM

Instructions: Cardholders requesting a replacement ID card or is updating information with the Medical Cannabis Program (MCP) must complete the appropriate sections below. If a processing fee is required submit a check or money order in the amount of \$25 made payable to the Vermont Medical Cannabis Program. More than one selection can made on this form below. Only one \$25 fee is required per form regardless of the number changes selected below requiring a fee. Change/Request Forms are normally processed within 2 business days from receipt

Please include the following information for processing:

First Name: _____ Last Name: _____ DOB: _____
 (Currently on file or as shown on your current ID card for those requesting a change of name.)

1. **CHANGE OF NAME** Enter your name as it should appear on your new ID card. (Processing fee required):

First Name: _____ M.I. _____ Last Name: _____

2. **REPLACEMENT CARD** (Processing fee required):

Lost/Stolen card Other (please specify: _____)

3. **CHANGE DESIGNATED DISPENSARY** (Check only one, processing fee required):

- | | |
|--|---|
| <input type="checkbox"/> CeresMED (<i>Burlington & South Burlington</i>) | <input type="checkbox"/> Grassroots Vermont (<i>Brandon</i>) |
| <input type="checkbox"/> PhytoCare Vermont (<i>Bennington</i>) | <input type="checkbox"/> CeresMED South (<i>Brattleboro & Middlebury</i>) |
| <input type="checkbox"/> Vermont Patients Alliance (<i>Montpelier</i>) | |

4. **DISPENSARY COMMUNICATION & DELIVERY** (No fee required):

(Dispensaries are **REQUIRED** to maintain **ALL** patient and caregiver information as confidential in conformity with HIPAA. This authorization may be withdrawn at any time.)

May the Medical Cannabis Program (MCP) provide your address, phone number, and email (if applicable) to your designated dispensary? Yes No

5. **ADD/CHANGE CULTIVATION INFORMATION** (No fee required):

Physical address (where marijuana will be cultivated): _____

6. **CHANGE OF CONTACT INFORMATION** (No fee required):

Mailing Address: _____

City, State, Zip: _____

Physical Address: _____

City, State, Zip: _____ Telephone Number: _____

I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate.

SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY: Funds: _____ Amount: \$ _____ Date: _____ Processed: Date: _____ Initials: _____