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 • **Website:** www.ct.gov/dcp/mmp

Report of Lost, Stolen or Damaged Registration Certificate

Please Note: Replacement card payments will only be accepted by personal checks, money orders or cashier checks.
Replacement card applications will be process within 5 business days after the application has been received.

1. Please type or neatly print all required sections of the form.
2. After completing the form, you must sign and date it.
3. You must submit this form along with a **$35 administrative fee** to the Department of Consumer Protection, Attention Medical Marijuana Program at the above address, in order to receive a new card.
4. You may be contacted by the Department of Consumer Protection to confirm the information in this form before a new card will be mailed to you.
5. **Do not use the old card if it was damaged or later found**. Once this form is processed, the old card will be voided and law enforcement will be notified.
6. Personal check, money order or cashier check payments should be made payable to "Treasurer, State of CT".

Identifying Information		
I am a: ☐ Patient ☐ Caregiver		
Last Name:	First Name:	
Date of Birth:	Physician's Name:	
Home Address (including Apartment or Suite #):		
City:	State:	ZIP:

What was the card ID number for your current card (if known)? _____

When was the registration card lost, stolen or damaged? _____

Please write a brief statement describing what happened to the old card.

_____

_____

_____

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 the information in this form.	
Patient's Signature: ▶	Date Signed: