



# Medical Marijuana Program

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## Change of Dispensary Facility Form

**INSTRUCTIONS:** Please mail, e-mail or fax completed form to the Department of Consumer Protection, Attention Medical Marijuana Program, at the above addresses. **Your re-assignment is valid only after the Department has notified you.**

**IMPORTANT NOTICE:** A qualifying patient or primary caregiver may change the patient's designated dispensary facility no more than four (4) times per year.

### Section A: Patient Information

Name (First, Middle, Last):

Home Address (including Apartment or Suite #):

City:

State:

Zip Code:

Registration Certificate Identification Number:

Date of Birth:

### Section B: Reason for Re-assignment (Reason required if more than 4 times per year.)

Current location too far for travel

Current location closing/moving

Specific marijuana strain not available at the current location

Other: \_\_\_\_\_

### Section C: Current Dispensary

Current Dispensary Facility Name:

Current Dispensary Facility Address:

City:

State:  
CT

Zip Code:

### Section D: New Dispensary Facility Information

New Dispensary Facility Name:

New Dispensary Facility Address:

City:

State:  
CT

Zip Code:

**I hereby certify that the above information is correct and complete.**

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: