Oregon Medical Marijuana Program
PO Box 14450
Portland, OR 97293-0450
(971) 673-1234 (Mon – Fri, 9:00am - 4:00pm)
www.healthoregon.org/ommp

Office Use Only

CHC	GR4	
FS	OHP	SSI

APPLICATION FORM Type or print legibly. Do not alter this form or use white out.

PATIENT – REQUIRED

LEGAL NAME (Last, First, MI):	☐Male ☐Female	DATE OF BIRTH:
MAILING ADDRESS:		PHONE:
CITY: STATE: ZIP:		COUNTY:
PHOTO ID # AND ISSUING AGENCY(Enclose Copy):		

CAREGIVER – OPTIONAL (*Complete **ONLY** if you have a Caregiver)*

LEGAL NAME (Last, First, MI):	☐Male ☐Female	DATE OF BIRTH:
MAILING ADDRESS:		PHONE:
CITY: STATE: ZIP:		COUNTY:
PHOTO ID # AND ISSUING AGENCY (Enclose Copy):		

GROWER/GROWSITE– OPTIONAL (*Complete **ONLY** if you have a Grower/Growsite)*

*****CANNOT BE A DISPENSARY*****

LEGAL NAME (LAST, FIRST, MI):	☐Male ☐Female	DATE OF BIRTH:
MAILING ADDRESS:		PHONE:
CITY: STATE: ZIP:		COUNTY:
PHOTO ID # AND ISSUING AGENCY(Enclose Copy):		

GROWSITE ADDRESS:

CITY:	STATE: **Oregon**	ZIP:	COUNTY:

FEES – REQUIRED The correct fee must be enclosed. If you are unsure please contact the OMMP.

NO GROWER/GROWSITE, OR PATIENT IS HIS/HER OWN GROWER, AND:

Submits no reduced fee proof:	$200.00
Submits current SNAP proof:	$60.00
Submits current OHP proof:	$50.00
Submits current SSI ***OR*** Vet 100% disability proof:	$20.00

PATIENT IS DESIGNATING GROWER OTHER THAN HIM/HERSELF, AND:

Submits no reduced fee proof:	$250.00
Submits current SNAP proof:	$110.00
Submits current OHP proof:	$100.00
Submits current SSI ***OR*** Vet 100% disability proof:	$70.00

OMMP FEES ARE NON-REFUNDABLE. Enclose check or money order payable to OMMP. This form must be sent with the payment. Do not staple or tape. See reverse for information on documentation required for fee types.

PATIENT SIGNATURE & DATE – REQUIRED

I TESTIFY THAT THE ABOVE INFORMATION IS TRUE:

PATIENT SIGNATURE: DATE:

DO NOT FAX – Contact the OMMP to request this document in an alternative format.

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Application Form Instructions

PATIENT INFORMATION – REQUIRED

- Patient information is required and this section must be completely filled out.
- Additional requirements must be met if the Patient is under the age of 18.

CAREGIVER INFORMATION – OPTIONAL

- If the Patient chooses to have a Caregiver, this section must be completely filled out.
- A Caregiver is not required if the Patient is 18 or older.

GROWER/GROWSITE INFORMATION – OPTIONAL

- If the Patient chooses to have a Grower/Growsite, this section **must** be completely filled out.
- A Dispensary may ***not*** be designated as either a Grower or a Growsite.
- The Authority must conduct a criminal history check on every Grower per ORS 475.304(6)(a).
- An additional fee is required if the designated Grower is not the Patient.

FEES – REQUIRED

$200.00 No reduced fee proof is submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.

$250.00 No reduced fee proof is submitted. A Grower/Growsite is listed and the Patient and Grower on the application are different people.

$60.00 Current proof of Oregon **Supplemental Nutrition Assistance Program (SNAP)** receipt is submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.

$110.00 Current proof of Oregon **Supplemental Nutrition Assistance Program (SNAP)** receipt is submitted. Grower/Growsite is listed and the Patient and Grower on the application are different people.

$50.00 Current proof of **Oregon Health Plan** receipt eligibility is submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.

$100.00 Current proof of **Oregon Health Plan** receipt eligibility is submitted. Grower/Growsite is listed and the Patient and Grower listed on the application are different people.

$20.00 Current proof of **Supplemental Security Income**[1] receipt eligibility is submitted. No Grower/Growsite or the Patient is his/her own Grower.

$70.00 Current proof of **Supplemental Security Income**[1] receipt eligibility is submitted. Grower/Growsite is listed and the Patient and Grower on the application are different people.

$20.00 Current proof of either **service connected compensation from the VA based on a finding of 100% service connected disability OR receipt of a needs-based pension from the VA as described in OAR 333-008-0020** is submitted. Grower/Growsite is listed or the Patient is his/her own Grower.

$70.00 Current proof of **service connected compensation from the VA based on a finding of 100% service connected disability OR receipt of a needs-based pension from the VA as described in OAR 333-008-0020** is submitted. Grower/Growsite is listed and the Patient and Grower on the application are different people.

[1] NOTE: **Social Security Disability Income (SSDI) and Social Security Retirement benefits *do not qualify*.**

Patient mail complete application, Attending Physician Statement, ID copies, and check or money order to:

OHA/OMMP
PO Box 14450
Portland, OR 97293-0450

You must present your original, valid OMMP card to enter a medical marijuana dispensary. (OAR 333-008-1230, 333-008-1245)
A dispensary will NOT accept a copy of your application and proof of transmission under any circumstances.

Until this application has been approved or denied by the Oregon Medical Marijuana Program, a copy of these materials (along with proof of mailing or transmission) shall have the same legal effect as a registration card. ORS 475.309(9).	The Oregon Medical Marijuana Act neither protects marijuana plants from seizure nor individuals from prosecution if the federal government chooses to take action against patients, caregivers, or growers under the federal Controlled Substances Act.

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