Medical Marijuana Program

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Fax: (860) 706-5361 • **E-mail:** dcp.mmp@ct.gov • **Website:** www.ct.gov/dcp/mmp

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: