Arkansas Department of Health

Patient or Caregiver Registry Information Change Request

Mail completed form to: Arkansas Dept. of Health, Medical Marijuana Section
4815 West Markham Slot 50
Little Rock, AR 72205

Cardholder Information (OLD)			
First Name	MI	Last Name	Phone
Street Number and Name (or PO Box)			
Unit Type (Apt, Unit, Suite, etc.)	Unit Number		
City	State AR	Zip Code	

Cardholder Information (NEW)			
First Name	MI	Last Name	Phone
Street Number and Name (or PO Box)			
Unit Type (Apt, Unit, Suite, etc.)	Unit Number		
City	State AR	Zip Code	

Medical Marijuana Registry Card ID (if known)			
Registry Identification Code 4d	Expiration 4b	Document ID Code 5	Date of Birth (MM/DD/YYYY) 3

Card Replacement

☐ Need replacement card

Reason for Change

☐ Name change (attach documentation)

☐ Address Change

☐ Cancel (No longer wanted or needed) Card #:

☐ Add Caregiver	Name	DOB (MM/DD/YYYY)	Registry Identification Code
☐ Remove Caregiver	Name		

☐ Other reason:

Date when change will take place

Date (MM/DD/YYYY)

I affirm the information stated here is accurate and true. I understand the issuance of a new ID card will render any and all previous ID cards void. Usage of a lost, stolen or voided card may affect your current and/or future Arkansas Medical Marijuana Registry ID status.

Signature	Date (MM/DD/YYYY)