FLORIDA DEPARTMENT OF HEALTH
Office of Compassionate Use
Low-THC Cannabis & Medical Cannabis

Rick Scott, Governor of the State of Florida
Celeste Philip, MD, MPH, Surgeon General and Secretary

FloridaHealth.gov

4052 Bald Cypress Way, Tallahassee, Florida 32399-3265 • 850-245-4657

Change, Replacement or Surrender Request Instructions

In order to change, replace or surrender your Compassionate Use Registry Identification Card, complete the Cardholder Information section and applicable section(s) of this form. By providing your email address, you consent to the Department contacting you through that email address.

To request a replacement card in the event of damage/loss/theft or change address:

- Complete section A of this form
- Include a copy of your Florida driver license or Florida identification card

To change your name :

- Complete section B of this form
- Include a copy of your Florida driver license, Florida identification card, or a copy of your marriage certificate, divorce decree or other court document to show your name change.

To change your legal representative:

To remove your legal representative
- Complete section C of this form

To change or add a legal representative
- Complete section C of this form
- Have your new legal representative complete a Compassionate Use Registry Identification Card Legal Representative Application
- If a new legal representative is signing on behalf of the patient to change or add a legal representative, the new legal representative must sign this form.

NOTE: Replacement, name or address change, and legal representative change cards will require the submission of this form, along with a $15 check or money order (application fee) made out to Florida Department of Health.

To surrender your card:

- Complete section D of this form
- Include your Compassionate Use Registry Identification card

For minor patients: The parent or designated legal representative's signature is required on all forms for minor patients, along with a copy of the parent or designated legal representative's Florida driver license or Florida identification card or other proof of Florida residency as stated in Rule 64-4.011(2)(a).

MAIL COMPLETED REQUEST TO:

Florida Department of Health
ATTN: Office of Compassionate Use
4052 Bald Cypress Way
Tallahassee, FL 32399

Rick Scott, Governor of the State of Florida
Celeste Philip, MD, MPH, State Surgeon General

FloridaHealth.gov

4052 Bald Cypress Way, Tallahassee, Florida 32399-3265 • 850-245-4444

Change, Replacement or Surrender Request

Mail Completed Request to: Florida Department of Health ATTN: Office of Compassionate Use 4052 Bald Cypress Way Tallahassee, FL 32399	☐ Patient	☐ Legal Representative
	Patient Registry ID #:_____	

This is a request to:

- ☐ Receive a replacement card
- ☐ Change my name
- ☐ Surrender my card
- ☐ Change, add, or remove a legal representative
- ☐ Change my address

Cardholder Information The address below is where the card will be mailed					
First Name		Last Name			Middle Initial
Date of Birth	Social Security Number	Mailing Address *(new address if applicable)*			
City	Apt/Ste #	State	Zip Code		County
Telephone	Email (optional to receive communication by email)				

A. Request a Replacement Card				
Card Number (if known):	Date of Damage/loss/theft: (if applicable)			
Reason for replacement:	☐ New address	☐ Damaged	☐ Lost	☐ Stolen

B. Name Change (Include a copy of the document that proves name change)			
New Name	First Name	Last Name	Middle Initial
Old Name	First Name	Last Name	Middle Initial

C. Change, add, or remove legal representative			
☐ Change my legal representative ☐ Add legal representative ☐ Remove my legal representative			
Current Rep	First Name	Last Name	Middle Initial
New Rep	First Name	Last Name	Middle Initial

D. Request to Surrender		
Card status:	☐ I have included my card	☐ I have not included my card

I hereby certify the above information to be accurate and complete and no one other than me, or my legal representative, is submitting this request on my behalf.	
Patient or Legal Representative Name *(Print)*	
Patient or Legal Representative Signature	Date

NOTICE ON THE COLLECTION, USE, OR RELEASE OF SOCIAL SECURITY NUMBERS

Florida law requires that public agencies provide individuals with a written statement identifying the state or federal law governing the collection, use, or release of social security numbers for each purpose for which the public agency collects an individual's social security number. The collection of social security numbers by the Florida Department of Health is either specifically authorized by law or imperative for the performance of the Florida Department of Health's duties and responsibilities as prescribed by law. This notice is provided pursuant to Subsection 119.071(5)(a), Florida Statutes. For the Change, Replacement or Surrender Request, social security numbers are collected and used for identification purposes to ensure that the number identifiers match the identities of the cardholder, as authorized by sections 119.071(5)(a)2. and 119.071(5)(a)6., Florida Statutes. Social security numbers collected for this purpose will remain confidential.