

Release of Patient Cardholder Status

* - required fields

Please complete and return this form by mail to: Office of Medical Cannabis, 350 Capitol Street, Room 523, Charleston, WV 25301 or by email to: medcanwv@wv.gov.

PATIENT/CAREGIVER INFORMATION:			
PATIENT ID NUMBER: _____ *		CAREGIVER ID NUMBER (if applicable): _____	
Full Legal Name: *		Date of Birth: *	
Patient Address: *			
City: *	State: *	County: *	Zip: *
Phone Number: *		Email:	
<p>I hereby authorize the Office of Medical Cannabis to release the status of my medical cannabis patient and/or caregiver participation as a current (valid) or invalid card holder in the State of West Virginia to the following:</p> <p><input type="checkbox"/> Business <input type="checkbox"/> Individual</p> <p>Name/address/email and phone number of entity/person to be released to: *</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
Print Full Legal Name (First, Middle, Last): *			Date: *
Signature: *			

FOR OMC OFFICE USE ONLY

This card is currently: Active Inactive Issued Date _____ Expiration Date _____

Information provided has been verified by:	Title:	Date: