

**Medical Marijuana Program
DENIAL APPEALS APPLICATION
(Please Print)**

Instructions: Use this form to appeal your county's denial of your application for a Medical Marijuana Program Identification Card. This form must be completed by you (the applicant) or by the legal representative specified below in Section 3. Within 30 calendar days from the date you were notified of your application denial, mail this completed form and a copy of your denied application to:

California Department of Public Health
Public Health Policy and Research Branch
Medical Marijuana Program - Appeals
MS 5202
P.O. Box 997410
Sacramento, CA 95899-7377

For further information, please contact the Medical Marijuana Program at (916) 552-8600.

Note: In order to process this appeal, the California Department of Public Health (CDPH) requires all applicable sections on this form be complete, including the signed declaration. Failure to furnish the authorization in Section 5 and all information required on this form will result in a denial of the appeal.

SECTION 1: INDICATE BY CHECKMARK BELOW IF THIS APPEAL IS FOR YOURSELF (APPLICANT), YOUR PRIMARY CAREGIVER, OR BOTH

Patient (applicant) card Primary caregiver card

SECTION 2 COMPLETE THE APPLICANT INFORMATION BELOW.

Name (last, first, middle initial)

Mailing address (number, street)

Telephone number
()

City

State

ZIP code

County of residence

SECTION 3 COMPLETE THIS SECTION IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Name (last, first, middle initial)

Telephone number
()

Mailing address (number, street)

City

State

ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

- I am the conservator for the applicant and I have authority to make medical decisions.
 I am an attorney-in-fact under a durable power of attorney for health care.
 I am a surrogate decision maker authorized under an advanced healthcare directive.
 I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

Parent Legal Guardian Other (*please specify*): _____

SECTION 4 COMPLETE THIS SECTION IF THE APPEAL IS FOR YOUR PRIMARY CAREGIVER.

Name (last, first, middle initial)

