



# OKLAHOMA MEDICAL MARIJUANA AUTHORITY PATIENT WITHDRAWAL OF CAREGIVER FORM

Website: [OMMA.ok.gov](http://OMMA.ok.gov) | Email: [OMMA@ok.gov](mailto:OMMA@ok.gov) | Phone: (405) 522-OMMA

This form is to be completed if a patient wishes to withdraw his or her current licensed caregiver. Submission of this form will result in the invalidation of the identified caregiver's license. In order to obtain another caregiver, the patient must have another individual complete a caregiver license application and be approved for a license. **PLEASE CLEARLY PRINT OR TYPE**

## PATIENT INFORMATION

First Name	Middle Name	Last Name	Suffix	Date of Birth (mm/dd/yy)
Current Physical Street Address		APT#	City	State Zip
County	Phone #	Email	Medical Marijuana Patient License Number	

## CAREGIVER INFORMATION — (for the caregiver you wish to withdraw)

The caregiver's full name is required; please provide as much information as you can.

First Name	Middle Name	Last Name	Suffix	Date of Birth (mm/dd/yy)
Current Physical Street Address		APT#	City	State Zip
County	Phone #	Email		

## PATIENT SIGNATURE

**By my signature below I attest to the following:**

- I understand I am withdrawing the caregiver identified above as my designated caregiver;
- I understand this request is not subject to appeal; and
- I understand this request will result in the lack of a licensed caregiver until another individual I designate completes a caregiver license application and is approved for a license.

 Patient Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

## (If applicable) PATIENT'S LEGAL GUARDIAN SIGNATURE

Printed Name: \_\_\_\_\_

 Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_