REGISTRATION CARD REPLACEMENT FORM

In the event that a patient or caregiver experiences the theft, loss, or destruction of their registration card, you must submit a "Registration Card Replacement Form" within (72) hours after the initial discovery.

Patient _____ Name _____ Date of Birth **Caregiver** _____ Registration Number (if known)	
Reason for Card Replacement (check one)	☐ Card was lost ☐ Card was destroyed ☐ Card was stolen …….Date Stolen: _____ Other (*specify*) _____
Replacement Fee Fees may be paid by credit or debit card, check, certified check, money order or cashier's check. Checks must be made payable to the **DC Treasurer**. No starter checks.	☐ $90.00 ☐ $20.00 for patients or caregivers whose income is equal to or less than two hundred percent (200%) of the federal poverty level In verifying income for reduced fees, applicants must submit proof of the following: Proof of being a current Medicaid or DC Alliance recipient; or Documentation verifying that the applicant's total gross income, including child support payments, alimony and rent payments received and any other income received on a regular basis is equal to or less that 200% of the federal poverty level, as defined by the US Department of Health and Human Services. ***In verifying income for the purposes of this qualification, an individual may submit the following:*** • Earnings statements received within the previous thirty (30) days; • District of Columbia or Federal tax filing returns for the most recent tax year; • For newly employed applicants, a verifiable copy of an offer of employment that states the amount of salary to be paid; • A copy of a Social Security or worker's compensation benefit statement; • Proof of child support or alimony received; • Any other unearned income or assets, including but not limited to, stocks, bonds, annuities, private pension and retirement accounts; or • Any other item(s) of proof deemed by the Alcoholic Beverage Regulation Administration reasonably calculated to demonstrate a person's current income.

I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge.

_____ Signature _____ Date

Applicants can submit their application by emailing medicalcannabis@dc.gov, mail, or ABRA's Self-Service Kiosk located immediately outside ABRA's office doors.

- Alcoholic Beverage Regulation Administration (ABRA):
  2000 14th Street, NW, Suite 400 South, Washington, DC 20009