Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

Returning Patient MMJ Card Information

Please ensure the following information is accurate and legible as it will be used to submit your card application to the Health Department.

First & Last Name ______________________________

Residential Address [No PO Box]

Street ______________________________

City ______________________________ Zip ____________

Phone Number ______________________________

Email [required by AzDHS] ______________________________

Mailing Address

☐ Same as residential ☐ Alternate Address [fill in below]

Street ______________________________

City ______________________________ Zip ____________

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☐ ☐ **Are You a Veteran?**

☐ ☐ **Social Security Disability**

☐ ☐ **AZ SNAP / EBT Program [Food Stamps]**
To qualify for the program discount offered by the Health Department, you must provide a copy of your SNAP/EBT card [if it shows your name] or your Award Letter.

☐ ☐ **Would you like to cultivate**
To Qualify for cultivation, you must live more than 25 miles from an operating dispensary.

By signing below, I attest that the information I provided above is accurate, and agree to be responsible for any potential fees if I need to change the information with the Health Department.

Signature Patient ____________ Patient Name [Printed] ____________ Date ____________

If needed, Signature of authroized representative ____________ Representative Name [Printed] ____________ Relationship to patient ____________ Date ____________

Authorized Facility Signature ____________ Date ____________